State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** March 30, 2006 Carl Joseph Reber 5:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, May 3, 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs 86 Pennsylvania 170-07-9575 Director Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Show or 28a-f show a notified at 1 ☐ Yes 2X No Maryland Montgomery Rockville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai', or items 23a or Exposiner coust be 7006 Old Cabin Lane 20852 United States death v 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No 1938 — Yes, Give 1964 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Š 3 Widowed 4 Divorced "natural" al Hygiene. I other than "nature ivent, the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Finance Officer Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) of Heelth and Mental H litem 27 is marked off r other traumatic ever Be Peges 1 and 2 should be Florence Seidel Leroy Reber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7006 Old Cabin Lane, Rockville, MD Virginia S. Reber/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) April 3, 20c. Location - City or Town, State 20a. Method of Disposition Department of the Importent: if its eny injury or of once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Montgomery Crematorium Bethesda, Maryland Robert A. Pumphrey Funeral Home, Rockville, In 300 W. Montgomery Avenue, Rockville, MD 20850 21. Signature of Funeral Service Licenski William a. Kompluly MO1173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia Physician /Medical Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter the criping Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami Sepsis Due to (or as a consequence of): inch 30,2006 01000m vision of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 1 Yes 2 No After this certification funeral director, p Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Hospital: 1 📉 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 🖾 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Naturat 5 Pending death. 1 Tes 2 No investigation i Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ŏ within 24 hours el To the Funerel D completely filled i 1 🖔 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur 42845 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8830 Cameron Street #333, Silver Spring, MD Stephen T. Michaels, M.D. 31. Date filed (Month Pay, Year) 5 32 Registrar's Signature State 2006 Registrar

			1 - State Amend Item	n zsa per	Dr.,6	334 _{Ce}	tiricate of t	Beath	R	eg. No.	10006
	Physici	an	Decedent's Name (First, Middle, La		11	_			2. Date of Dea Month	th Day Yea	3. Time of Death
	/Medic		May	5 m	-	· · · · · · -	# 05 T		March	22 200	
	Examin	er	4a. Facility Name (If not institution, give 3724 St. Marg				4b. City, Town, or Ba	location of Deat	n	4c. County of D	eath
	Funeral		Social Security Number 6. S	Sex 7. A		last birthday)	If Under 1 Year	If Under 24 Hrs Hours Min.	8. Date of Birth		Birthplace (State or Foreign
L	Director		214 20 9303	I□M 2∏F	77	Yrs.	Months Days	Hours Min.	March 2	3,1928 M	aryland
	land w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f sh	tor	Maryland N/A		В	altimo	re				1 ☑ Yes 2 ☐ No
	or 284	Director	10e. Street and Number	_			10f. Zip Code		1	log. Citizen of What	Country?
	s 23s	ral	3724 St. Marga	· · · · · · · · · · · · · · · · · · ·			212			U.S.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 ie marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 If Yes, Give Year or Dates	s?] No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 212 No	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		mencan Indian, Thite, etc. Vhite
2	72 ho	eted	15. Decedent's E (Specify only highest gra			(Give	dent's Usual Occupa	during most of wo	rkina	16b. Kind of Busine	ess/Industry
21215-0036	within one. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)	life.	DO NOT use retired etary)		Brook1vn	Bible Chapel
	filed v Hygie other 1	ပိ	8th 17. Father's Name (First, Middle, Last,)		Beer	Ctury	18. Mother's Na	me (First, Middle,		Divie Chaper
<u>la</u> n	Aentel	To Be	Benja	amin Frank	lin H	[a11		Mar	y Elizabe	eth Shento	on
Maryland	2 shot and h le ma		19a. Informant's Name/Relationship (1	_			r, City or Town, Stat	
	1 and lealth orn 27 ther tr		Gerald Smith, Si	c. / Son	20h P	-	St. Marga	aret Str	eet Balt Date	imore, Ma	aryland 21225
20	ages int of l t: If ite		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		e _ c	emetery, crei	natory or other place 11 Cemete				, Maryland
Baltimore,	nait. Positime cortan		21. Signature of Funeral Service Lice	• •	1000					eral Serv	
ö	P G E S	gi.	Honna M	rameso	ust	// .					ryland 21225
Ī			23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that cause one cause on each	ed the death line.	n. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		nev	moh	10				IWEEK
											, , , ,
	Examiner			Due to (or a	s a consequ			nia Aspi	ration		Iweek
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	b. Due to (or a	Pin	uence of):		nia A spi	ration		I week
	Examiner	xaminer	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for a	s a consequ	uence of):		nia Aspi	ration		Ineck
,09	Examiner	Examin	ff any, reading to immediate cause. Enter Underlying Cause (Disease or injury	b. Gs	s a consequ	uence of):		nia Aspi	ration		I week.
68760,	cate be executed by physiclen and the burial-transit	dical Examin	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to for a	s a consequ	uence of):		nia A spi	ration		Iweek.
Box 6	death certificate be executed by the attending physician and did for use es the burial-transit	dical Examin	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to for a	s a consequence of pregna 2 Fetal	uence of): uence of): uence of):			ration	23d. Date of Month	I week.
P.O. Box 6	death certificate be executed by the attending physician and did for use es the burial-transit	dical Examin	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Dive birth 4 Pregnant: 9 Unknown	s a consequence of pregna 2 ☐ Fetal at time of de	uence of): uence of): uence of): uence of):	Pneumo			Month	J week.
P.O. Box 6	death certificate be executed by the attending physician and did for use es the burial-transit	by Physician/Medical Examin	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Dive birth 4 Pregnant: 9 Unknown	s a consequence of pregna 2 ☐ Fetal at time of de	uence of): uence of): uence of): uence of):	Pneumo			Month bacco use contribut	delivery Day Year
P.O. Box 6	requires that the death certificate be executed by the standard physicien and thould be deteched for use es the burial-transit	by Physician/Medical Examin	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Dive birth 4 Pregnant: 9 Unknown	s a consequence of pregna 2 ☐ Fetal at time of de	uence of): uence of): uence of): uence of):	Pneumo		23e. Did to 1 📉 24a. Was a autop.	Month bacco use contribut es 2 □ No 3 □ an 24b. Were sy	delivery Day Year e to the cause of death? Probably 4 Unknown a autopsy findings available to completion of cause of
P.O. Box 6	The law requires that the death certificate be executed by the standard physicien and bage 2 should be deteched for use es the burial-transit	Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 100 9 Unknown Part II. Other significant conditions of the past 12 months?	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Dive birth 4 Pregnant: 9 Unknown	s a consequence of pregna 2 ☐ Fetal at time of de	uence of): uence of): uence of): uence of):	Pneumo	en in Part I.	23e. Did to 1 🖂 Y 24a. Was a autoppendor 1 🗀 Yes	Month bacco use contribut es 2 No 3 an 24b. Were sy med? deat 2 No 1	delivery Day Year e to the cause of death? Probably 4 Unknown a autopsy findings available to completion of cause of
P.O. Box 6	The law requires that the death certificate be executed by the standard physicien and bage 2 should be deteched for use es the burial-transit	o Be Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Dive birth 4 Pregnant: 9 Unknown	e of pregna 2 Fetal at time of de	uence of): uence of): uence of): uence of):	Pricumo	en in Part I.	23e. Did to 1 🗹 Y 24a. Whas autopperfor 1 Yes ath Check only or	Month bacco use contribut es 2 No 3 an 24b. Were sy prior deatt 2 No 1	delivery Day Year e to the cause of death? Probably 4 Unknown a autopsy findings available to completion of cause of 1? Yes 2 140
P.O. Box 6	The law requires that the death certificate be executed by the standard physicien and bage 2 should be deteched for use es the burial-transit	To Be Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 HNo 9 Unknown Part II. Other significant conditions of the past 12 months?	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant: 9 Unknown contributing to death Hospital: 1 Inpat 28a. Date of In (Month, D	e of pregna 2 Fetal at time of de but not resu	uence of): uence	Preumo	en in Part I. 26. Place of De er: 4 Nursing I	23e. Did to 1 📉 24a. Was a autopoperfor 1 🗆 Yes ath *Check only or* Home 5 *Tlesid	Month bacco use contribut es 2 No 3 an 24b. Were sy med? deat 2 No 1	delivery Day Year e to the cause of death? Probably 4 Unknown a autopsy findings available to completion of cause of 1? Yes 2 140
O. Box 6	The law requires that the death certificate be executed by the sate of the second of the sate of the burial-transit bage 2 should be deteched for use es the burial-transit of	ertification; To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 lot No 9 lunknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner? 1 yes 2 lot No 27. Manner of Death 1 Natural 5 Pending	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown contributing to death A Hospital: 1 Inpat 28a. Date of In (Month, D) 18	s a consequence of pregna 2 Fetal at time of definition to the street of	uence of): uence	Preumo	en in Part I. 26. Place of De er: 4 □ Nursing I	23e. Did to 1	Month bacco use contribut es 2 No 3 an prior deat 22 No 1 No 1 one) ence 6 Other (So ow injury occurred	delivery Day Year e to the cause of death? Probably 4 Unknown a autopsy findings available to completion of cause of 1? Yes 2 140
P.O. Box 6	The law requires that the death certificate be executed by the sate of the second of the sate of the burial-transit bage 2 should be deteched for use es the burial-transit of	Certification; To Be Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yo 9 Unknown Part II. Other significant conditions of the cond	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown contributing to death A Hospital: 1 Inpat 28a. Date of In (Month, D 10 28e. Place of In building, c nysician: To the bass and manners	e of pregna 2 Fetal at time of de but not resultient 2 injury lay Year) njury - At hoelc. (Specify st of my knood of examinal stated.	uence of): uence	Preumon City Other (specify) Int 3 DOA Cther At 3 DOA Cther Careet, factory, office Choccurred at the time vestigation, in my of	26. Place of De er: 4 □ Nursing I y at Yes 2 □ No ne, date and place pinion, death occ	23e. Did to 1 1 7 Yes 24a. Was a autopoperfor 1 1 Yes ath Check only or Home 5 1 esid 28d. Describe h 28f. Location (S City or Tow	Month bacco use contribut es 2 No 3 an 24b. Were prior deat 22 No 1 No 1 ence 6 Other (5 ow injury occurred treet and Number on, State) cause(s) and manne late and place, and	delivery Day Year e to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of 17? Yes 2 No Specify) r Rural Route Number, r as stated, due to the cause(s)
P.O. Box 6	requires that the death certificate be executed by the standard physicien and thould be deteched for use es the burial-transit	ertification; To Be Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yo 9 Unknown Part II. Other significant conditions of the cond	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown contributing to death A Hospital: 1 Inpat 28a. Date of In (Month, D 10 28e. Place of In building, c nysician: To the bass and manners	e of pregna 2 Fetal at time of de but not resultient 2 injury lay Year) njury - At hoelc. (Specify st of my knood of examinal stated.	uence of): uence	Preumon City Other (specify) Int 3 DOA Cther At 3 DOA Cther Careet, factory, office Choccurred at the time vestigation, in my of	26. Place of De er: 4 □ Nursing I y at Yes 2 □ No ne, date and place pinion, death occ	23e. Did to 1 1 7 Yes 24a. Was a autopoperfor 1 1 Yes ath Check only or Home 5 1 esid 28d. Describe h 28f. Location (S City or Tow	Month bacco use contribut es 2 No 3 an 24b. Were prior deat 22 No 1 No 1 ence 6 Other (5 ow injury occurred treet and Number on, State) cause(s) and manne late and place, and	delivery Day Year e to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of 17? Yes 2 No Specify) r Rural Route Number, r as stated, due to the cause(s)
P.O. Box 6	The law requires that the death certificate be executed by the sate of the second of the sate of the burial-transit bage 2 should be deteched for use es the burial-transit of	Certification; To Be Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Yo 9 Unknown Part II. Other significant conditions of the cond	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown contributing to death A Hospital: 1 Inpat 28a. Date of In (Month, D 10 28e. Place of In building, c nysician: To the bass and manners	e of pregna 2 Fetal at time of de but not resultient 2 injury lay Year) njury - At hoelc. (Specify st of my knood of examinal stated.	uence of): uence	Preumon City Other (specify) Int 3 DOA Cther At 3 DOA Cther Careet, factory, office Choccurred at the time vestigation, in my of	26. Place of De er: 4 □ Nursing I y at Yes 2 □ No ne, date and place pinion, death occ	23e. Did to 1 1 7 Yes 24a. Was a autopoperfor 1 1 Yes ath Check only or Home 5 1 esid 28d. Describe h 28f. Location (S City or Tow	Month bacco use contribut es 2 No 3 an 24b. Were prior deat 22 No 1 No 1 ence 6 Other (5 ow injury occurred treet and Number on, State) cause(s) and manne late and place, and	delivery Day Year e to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of 17? Yes 2 No Specify) r Rural Route Number, r as stated, due to the cause(s)
P.O. Box 6	The law requires that the death certificate be executed by the sate of the second of the sate of the burial-transit bage 2 should be deteched for use es the burial-transit of	Certification; To Be Completed by Physician/Medical Examin	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigations of the pending	b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown contributing to death A Hospital: 1 Inpat 28a. Date of In (Month, D 10 28e. Place of In building, c nysician: To the bass and manners	e of pregna 2 Fetal at time of de but not resultient 2 injury lay Year) njury - At hoelc. (Specify st of my knood of examinal stated.	uence of): uence	Preumon City Other (specify) Int 3 DOA Cther At 3 DOA Cther Careet, factory, office Choccurred at the time vestigation, in my of	26. Place of De er: 4 □ Nursing I y at Yes 2 □ No ne, date and place pinion, death occ	23e. Did to 1 1 7 Yes 24a. Was a autopoperfor 1 1 Yes ath Check only or Home 5 1 esid 28d. Describe h 28f. Location (S City or Tow	Month bacco use contribut es 2 No 3 an 24b. Were prior deat 22 No 1 No 1 ence 6 Other (5 ow injury occurred treet and Number on, State) cause(s) and manne late and place, and	delivery Day Year e to the cause of death? Probably 4 Unknown e autopsy findings available to completion of cause of 17? Yes 2 No Specify) r Rural Route Number, r as stated, due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Swift, Sr. Walter L. **Physician** 2006 7:00 P. M Apri1 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 405 Frankle Street Baltimore N/A If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**☑**M 2□F Months Days 218 10 7047 87 Director April 14,1918 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Mcdical Examinar must be notified at 1 XYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S. 405 Frankle Street 21225 or itams 23a death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene important: if item 27 is marked other than "natural", or item any injury or other traumatic ayant, the Mcdcal Exeminations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Super Fresh 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Swift ဨ Winifred (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Swift Jr. / son 1541 Hodges Avenue Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Lorraine Park Cem. 4/7/2006 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dementra **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Box 68760, Due to (or as a consequence of): Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2□ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□Yes 20No Other: Medical Certification; To 2 ER/Outpatient 4 Nursing Home 1 Inpatient 3□ DOA 5 Residence 6 □Other (Specify) ihis 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending s after de. al Director: Atte 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 134 31. Date filed (Month, Day, Year) State 5 APR 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#7, perFH, G854 4/5/06 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** George D. Sawyer arch 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore 8. Date of Birth (Month, Day, Year) 12-27-1922 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Md 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 83 82 213-14-8809 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iteme 23a or 28e-f show any njury or other traumatic event, the Medical Examinar must be notified at once. Yes 2 No **Funeral Director** Md N/A Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3904 Hilton Road Apt 150 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Black. Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A 2121 Elementary/Secondary (0-12) 8th grade Bethlehem Steel land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eva Gillium ဥ Fred Sawyer Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3904 Hilton Road Apt 150 Evelyn Sawyer - Wife Balto, Md 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Druid Ridge Cemetery 4-7-2006 Balto, Md 4 □ Denation 5 □ Other (Specify) March F/H West 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hompson Balto, Md 21215 Rome 4300 Wabash Avenue 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiradory Physician Zweecs /Medical Due to (or as a consequence of) Examiner Renal Houlure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner physicien and s the burial-transit X5051S Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten e detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown ۵. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 si autopsy performed? 1 Yes 2 No of Vital 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1☐Inpatient 2☐ER/Outpatient 3☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After Certification: 28d. Describe how injury occurred Hospital or Attending Division Injury 1. Natural 5 Pending To the Hospital or Attendin, within 24 hours effer death.
To the Funeral Director: Aft completely filled in by the fun М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 24 Certifying Physician: To the hest of my knowledge, death conumed at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D Merch 31, 2006

DHMH 17 Rev 1/2001

State Registrar

Samve

corge

8

attentonin

ORIGINAL

Sirou

Hospital of Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

STAVRO

31. Date filed (Month, Day, Year)

			For State Registrar	State of Ma	ıryland /		rtment tificate			and Me		ene	06	10505
	Discrete:		1. Decedent's Name (First, Middle, Last)								2. Date of Death Month	Day	Year	3. Time of Death
	Physici /Medio	al	Henry Charles		1						March	· · · · · · · · · · · · · · · · · · ·	006	2:15 P M
	Examir	er	4a. Facility Name (If not institution, give Gilchrist Center				4b. City,	Town, or 1	Location o	of Death		4c. County	timo,	
	Funeral		5. Social Security Number 6. Sec		(In yrs. last b	irthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day,	1	9. Birth	place (State or Foreign
	Director		219-01-8372	M 2□F	85	Yrs.	Months	Days	Hours	Min.	Aug. 30,	1920	Mar	yland
Т	pu .		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
	Aaryla f sho	ច	Maryland Baltimor	10			eltimo	th O						1 ☐ Yes 2 💢 No
	28a-	Director	10e. Street and Number	Le		Du	10f. Zip				10	g. Citizen of	What Cou	ntry?
	death with the Marylan ome 23a or 28a-f show ir mast be notified at		7285 Bridgewood	Drive					21:	224			u.s.	۹.
36	ē = Ē	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1. Yes 2 N If Yes, Give Year or Dates:			Vas Deced f Yes, spec	-	panic Ori , Mexican Specify:	gin? (Spec i, Puerto R	rify Yes or No- ican, etc.)	Bla	ce - Americk, White	
9	"naturel", or	ted	15. Decedent's Edu	cation	16	a. Deced	lent's Usua	I Occupa	tion		1	6b. Kind of B	usiness/Ir	ndustry
215	within 7; ene. then "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	+)	life. I	kind of wor DO NOT us	e retired)	-	t ot workin				0 0 '
2		Son	Elementary/Secondary (0-12) 11th Grade			Post	ial Ca	1		4 51				l Service
Maryland 21215-0036	P P P	To Be	17. Father's Name (First, Middle, Last) Francis X. Sch	ıneeman					Irei		(First, Middle, M Cumberl		пө)	
ary	d 2 should th and Men 7 is marks traumatic	-	19a. Informant's Name/Relationship (Ty				-				Route Number,			
	s 1 and 2 if Health Item 27 i		Mrs. Donna M. Zah	iner (daug	-				st w		altimor			
ore	of H		20a. Method of Disposition 1	lemoval from State	I	ery, crer	natory or o	ther place				Oc. Location		
Baltimore,			4 Donation 5 Other (Specify)		Sacre	ed He	eart o	of Je	esus	4/3/2	2006 B munek F	altimo	re,	Maryland
Bal	permit. Departr Imports eny inje		21. Signature of Funeral Service Licens But a U	Jille	ف						muner Fi xtimore			2. S
9	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	ne. Add	e (2 e of):		A N (cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death M. O. T. T. J.
D. Box 68760,	The law requires that the death certificate be executed to the second to the second physicien and page 2 should be detached for use as the burist-transit.	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as: d	of pregnancy 2 ☐ Fetal dea	th 3[Ectopic pr						ate of delik	very Day Year
P.0	thet the		Part II. Other significant conditions co	ntributing to death bu	ut not resulting	in the u	nderlying c	ause give	n in Part I		23e. Did tob	acco use con	tribute to	the cause of death?
ds,	uires n sign	d by	Coronary	Arter	y di	sei	950				1 ☐ Ye	s 2 No	3 🗆 Pro	bably 4 Unknown
of Vital Record	: The law requ cate has been page 2 shoul	Completed	,							_	24a. Was ar autopsy perform 1 \(\text{Yes} \) 2	ned?	Were aut prior to o death?	opsy findings available ompletion of cause of
/ita	iiclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					1		of Death	(Check only one			- ()
	hys his	2	1 Yes 2 No	1 _ Inpatie	y 28b	Outpatier Time of		8c. Injury Work	4 U NU		e 5 Reside 8d. Describe ho		ner <i>(Spec</i> rred	ity) Hospice
sior	Attending in death.	atio	f ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, 54)	, , , , , ,	injury	М		′es 2 🗆	No				
Division	하를	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulg		farm, str	eet, factory	, office		2	8f. Location (Str City or Town	reet and Num , State)	ber or Ru	ral Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	cai	(Check only of Medical Everni	sician: To the best oner: On the basis of	evamination	and/or in	vaction	in my on	inion dea	th occurre	d at the time da	te and place	and due	to the cause(s)
	To the Hospital within 24 hours of To the Funeral completely filled	Med	29b. Signature and title of certifier 30. Name and address of person who co 31. Date filed (Month, Day, Year) APR 0 5 2	and manner sta	7	w	290	: License	number	5	29 V	od. Date signe	ed (Month	Day, Year)
	10+1		30. Name and address of person who co	ompleted cause of d	eath (Item 23a	і) (Туре,	Prior)	7. 12	sala	to m	1213	208		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) APR 0 5 2	32. Po gistra	ar's Signature	A	borte	,						

Schneeman, Henry 3/30/06 215/pm

		1 - State of Registrar	Maryland / Den G854 4/5/06	artment of Health and M rtificate of Death	lental Hygien	2006 10506
Physic	ian	Decedent's Name (First, Middle, Last)				ay Year 3. Time of Death
/Medi	cal	ELISE J. SCOTT 4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or Location of Death	04.01.20	c. County of Death
Examin	ner		ME	TOWSON		BALTIMORE
Funeral Director		5. Social Security Number 6. Sex 1	Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 06 · 10 · 10	
iand ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
Many a-f eh	to	MD NA	BALTIMORI	E		1 Yes 2 □ No
or 28	Director	10e. Street and Number		10f. Zip Code	10g. C	citizen of What Country?
seth v			207	21229 Was Decedent of Hispanic Origin? (Spi	poits Van or Na	USA 14. Race - American Indian,
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28s-f show with highry or other treumatic event, the Medical Examinar must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2(N Married 3 □ Widowed 4 □ Divorced 12. Was Deceded Armed Force 1 □ Yes 2 If Yes, Give year or Date	as? No	was becedent to Hispanic Origin? (Spin If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 1 No Specify:	Rican, etc.)	Black, White, etc. Specify: BLACK
21215-0036 sd within 72 hours ef gjene. er then "naturel", or the Medical Exem	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during most of work.	ina 16b.	Kind of Business/Industry
121 Within	mp	Elementary/Secondary (0-12) College (1-4	or 5+)	DO NOT use retired) NURSE		ALTH CARE
d 2 filed v		17. Father's Name (First, Middle, Last)			i (First, Middle, Maide	
Maryland nd 2 should be file slith and Mental Hy 27 is marked oth	To Be	HERBERT M. SCOTT, SR.	JESSE MATTHI	BERTHA	MINSTON	
Mar 12 sho 10 m		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Rura		
Lenc 1 enc Heelit em 2:		HERBERT M. SCOTT, SR 20a. Method of Disposition	20b. Place of Dispo	ST. AGNES LN. BI		21229 Location - City or Town, State
Pages ent of nt: If I		1 ☐ Burial 2 E Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	cometan/ cros	matory or other place)		LTIMORE , MD
Baltimore, permit. Pages 1 ei Department of Hee Important: If Item any Injury or other		21. Signature of Funeral Service Licensee	22	2. Name and Address of Facility)·06 56	ETTHORE IND
a 88 8 8		Vangha CJ	5	REMATION SERVICES 151 BAUTO. NATI PIKE	, BAUD. A	1D 21229
Physician /Medical		23a. Part1. Enter(th) disease, or complications that cau shock, or heart failure. List only one cause on eac Immediate Cause (Final disease or condition resulting in death)	sed the death. Do not ent h line.		or respiratory arrest,	Approximate Interval Between Onset and Death
certificate be executed with a property of the purial-transit of t	dical Examiner	Sequentially list conditions. any lease to manadate cause. Enter Underlying Cause (Disease or injury that initiated events c.	as a consequence of): as a consequence of): as a consequence of):			
Box 6 auth certifi	Completed by Physician/Medi		n 2 ⊟Fetal death 3 [tat time of death 5 [□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
	ed by Ph	Part II. Other significant conditions contributing to deal	h but not resulting in the u	nderlying cause given in Part I.		o use contribute to the cause of death?
I Re	Comple				24a. Was an autopsy performed?	
of Vital F Physician: Th this certificete	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inc			Check only one	4
Division of To the Hospital or Attanding Phys within 2 hours after death. To the Funeral Director: After this completely filled in by the funeral di	ation; To	1 Yes 2 No 1 In Inc. 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		11 3 DOA Care: 4 Nursing Ho 128c, Injury at Work? 1 Yes 2 No	me 5 ☐ Residence 28d. Describe how in	6 Dother (Specify) VIOS ICE
Divis	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building	Injury - At home, farm, st., etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)
Hospi 24 hou Funer Hely fill	edical	(Check only 2 Medical Examiner: On the bas	s of examination and/or in	occurred at the time, date and place, vestigation, in my opinion, death occurr	and dua to the causared at the time, date a	e) and manner as stated. nd place, and due to the cause(s)
o the comple	Med	29b. Signature and title of certifier	Stateu.	29c. License number		Date signed (Month, Day, Year)
[]		160 M (000		40051926	Ge	wil 1, 2006
1		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print) 25 St Baltunare	, -4	
		Helen M. Garden 6565		es St Bathmore	u(0) 21	204
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	de la companya della companya della companya de la companya della		

DHMH 17 Rev 1/2001

STEVENSON

-OUISE

			For State	State of Maryland	·		Mental Hygi	iene	10508
			Registrar 1. Decedent's Name (First, Middle, Last,		Certificate o	r Death	2. Date of Death	h Day Year	3. Time of Death
Sig.	Physici /Medic	al	MEI-Ching BAN 4a. Facility Name (If not institution, give		4h City Town	, or Location of Death	MARCH	23 2006	4:00 PMM
	Examin	er	Laurel Regiona	1 11		UREL		RINGE CO	EORGE'S
*	Funeral Director		5. Social Security Number 6. Se		t birthday) If Under 1 Ye. Months Day		8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign buntty)
	D		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location		11-12-	72 117	10d. Inside City Limits
	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "natural", or iteme 23a or 28a-f ehow event, the Madical Expandrer must be multified at	tor	MD RINGE GE	ORAE'S L	AUREL				1 Pres 2 No
	with the a or 284 be not	Funeral Director	10e. Street and Number	> 0	10f. Zip Code		10	0g. Citizen of What Co	ountry?
	death me 23	nerai	8366 IMPERIAL 11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		708 If Hispanic Origin? (Spuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame	
36	rs after I', or its	by Fu	1 Never Married 2 Married 3 Vidowed 4 Divorced	1 ☐ Yes 2 ➡No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑	/	o riioari, otc.,	Black, Whit	SIAN
5-0036	72 hou natura	eted	15. Decedent's Edu (Specify only highest grad	cation	16a. Decedent's Usual Occ (Give kind of work do	cupation ne during most of wor	king	16b. Kind of Business/	
2121	filed within Hygiene. Ither then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	STOCK (LERY	1). S. COVE	RNMENT
and	ild be filed fental Hyg rked other ilc event,	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, N	Maiden Sumame)	
Maryla		은	UNKNOWA 19a. Informant's Name/Relationship (T)		19b. Mailing Address (Stre		KNOW ral Route Number,		Zip Code)
	and 2 ealth a n 27 ie		GORDONZ-SMITH		33dd Imfer	ALDR LAL		20708	
more,	m 0 - L		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	ce of Disposition ame of netery, crematory or other p		Date 2	20c. Location - City or	Town, State
a	permit. Page Department Importent: If eny injury or once.		21. Signature of Fundral dervice Licens	HNAT	22. Name and de	dress of Facility			-1137
m	<u>00599</u>		23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused the death.	Daugherty 260 Do not enter the mode of c	/ Family Funeral Ho 11 Mountain Road Ning, such as cardiac	ome And Cremai - Pasadena, Mi or respiratory arre	tion Center, P.A. D. 21122	Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line. RESO RATO		DE			Interval Between Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a conseque		,			
ağı	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):	ONIA			
	axecute n end al-trans	Examiner		Due to (or as a conseque	nce of):				
8760	death certificate be executed e attending physicien end id for use as the burial-transit	icai	(1					
Box 6	eath certific: attending pl I for use as t	n/Mec	fF FEMALE: 23b. Was decedent pregpant	3c. If yes, outcome of pregnance				23d. Date of def	fivery
Ö.	e death the atte	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ② No 9 ☐ Unknown	1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown				Month	Day Year
مأ	The law requires thet the de Ite has been signed by the a rage 2 should be detached i	by Phy	Part II. Other significant conditions co	ntributing to death but not result	ing in the underlying cause	given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ords	w require: been sig should be	ted b	SEPSIS				1 □ Ye	ıs 2 ☑ No 3 ☐ Pr	obably 4 Unknown
Records,	he law in a has be	Completed					24a. Was ar autopsy perform	ned? death?	utopsy findings available completion of cause of
Vital		Be Co	25. Was case referred to medical examiner?			26. Pface of Dea	1 ☐ Yes 2 th (Check only one	2 ₩ No 1 □ Yes	2 No
	Attending Physician: or death. ector: After this certification is the funeral director;	ဥ	1 Yes 2 No		Produpation 3 DOA			ence 6 Other (Spec	cify)
ion	ittending death. ctor: Afte	ation	1 Naturaf 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	Injury V	ljuryat Vork? □Yes 2□No	200. 2000.100 110	w many occurred	
Division of	or Att	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	ce	28f. Location (Str City or Town	reet and Number or Ru n, State)	ural Route Number,
_	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	edical C	29a. Certifier (Check only 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examination	edge, death occurred at the	time, date and place	, and due to the ca	ause(s) and manner as	s stated.
	To the Ho within 24 I To the Fu completely	Med	29b. Signature and title of gentaler	and manner stated.		ense number		9d. Date signed (Mont	
}	->-0		· TKOM	re mi)	Do	43351		3/29/06	
	7		30. Name and address of person who of	ompleted cause of death (Item 2	23a) (Type, Print)	1 5-A 11-	15 Clar	PAK MD	207/10
(3)	Sta		31. Date fifed (Month, Day, Year)	32. Registrar's Signatu	10 A D	y sould vi	1- Justey	· gr mp	عرب جن
100	Registr	ar	APR 0 5 2006	properties to	MARCHAN STATE OF THE STATE OF T				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Item #8 Per FH G854 4 Gertificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 11:10A HAN-tORD **Physician** 2006 VILMER /Medical 4c. County of Death 4a. Facility Name (Il not institution, give street and number)
BAHIMORE VA Repair + Extended
Case Center 4b. City, Town, or Location of Death NA Examiner Baltimore 8. Date of Birth (Month, Day, Year) Feb.04,1943 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Min. **Funeral** 63 Hours 1**X** M 2□ F MARULANCE 214-40-0033 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State the Medical Examiner must be notified at Yes 2 □ No 914more Funeral Director HARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21202 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? or Items 11. Marital Status 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Affican AMERICAN Specify: Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed by Year or Dates: "neturei" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DAHIMORE 1246 Wison 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental is marked o HARURU STAM mer ord ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stian Caughter Lexington Street 746 Pages 1 and 2 nent of Health a EA Himore WARY And AMURKA other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Baltimore, 20a. Method of Disposition ARRISON FOREST VA APRIL 12, 2006 Owing Mills Burial 2 ☐ Cremation 3 ☐ Removal from State 6 tment tent: 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
RANCY M. WALLACE FUNERAL SERVICE
3-LOST W. FRANKIN Street-BAHIMORE, MARGARD 21229 21. Signature of Funeral Service License Import any inj once 23a. Pert . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 26. Place of Death Check on one funeral director, 25. Was case referred to medical examiner? Be Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗆 Yes 2X No ို 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death ol or Attending P after death. I Director: After After Certification 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🔲 Suicide filled in by 4 Thomicide To the Hospitel o within 24 hours aff To the Funerel Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cegtifier 2006 D56508 UM 03 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + ANG RONG Berl. Baltimore, 21218 Raven 3900 Lock 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 4 2006 Registrar APR 0

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend 1 tem 7 per 1h 9854 4-5-06 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 78800 Xeelato 06 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Rehab.c UNV of AA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplece (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Devs 213-32-8346 1 M 2 KF Months Hours 89-Director Maryland Usuel Residence of Decedent e filed within 72 hours efter deeth with the Maryland of Hygiane. Other than "natural", or items 23a or 28s-f show 10e. State 10b. County 10c, City, Town or Location 10d. Inside City Limits ttem 27 is marked other than "natural", or items 23s or 28s-f shot other traumetic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 956 Princeton Terrace 21060

13. Was Decedent of Hispenic Origin? (Specify Yes or NoIf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify Completed by 3 ₩idowed 4 Divorced White 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A File Clerk Harbor Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden 12 should be fill h and Mantel H r is marked oth Be ٥ George Freeman Edith Cosby 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) os 1 and 2 s of Haalth an Dianna M. Vogel (Daughter) 11647 Baker Mill Road Seaford Delaware 19973 a of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Peges 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Injury Cedar Hill Cemetery 4/3/06 Brooklyn Park Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician theroscleratic Cardio Vascular Disecuse Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ed by the attanding physician and detached for use as the bunal-transit Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 40 Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? tor: After this certificate has been signed by the funeral director, paga 2 should be detact 2DNo 3□ Probably 4□ Unknown \$ Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 🗆 Yes 1 Tes Be 25. Wes case referred to medical 26. Place of Death (Check only one) examiner Other: 1 Yes 2500 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? . Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 2 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. aftar death Director: / 2 ☐ Accident investigation 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) filled in by 4 Homicide ō To the Hospital of within 24 hours a To the Funeral D 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier edical completely (Check only one) 2 29b. Signature and title of certified 29d. Date signed (Month, Dey, Year) 2010 anona

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

APR 0 5 2006

Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAKESH ARORA, MD 14300G ALC ANT FOX CN #222 BOWLE MD 20715

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryland				ealth a	and M		jiene lag. No.	06	10512
			1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		DOUGLAS R. SMA			,				Mooth	3	2006	09:354 M
	Examin		4a. Facility Name (If not institution, give 15101 ALLISON F			M	ONKT					LTIMO	RE
	Funeral Director		213-32-3334	7. Age (In yrs. I	ast birthday) Yrs.	If Unde Months	Days	If Under Hours		8. Date of Birth (Month, Day 01/14/	1920	Cou	place (State or Foreign intry) NSYLVANIA
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ocation							10d. Inside City Limits
	Mary Feb	ģ	MD BALTIMO	ORE M	ОИКТО	N							1 ☐ Yes 2 No
	or 28g	Funeral Director	10e. Street and Number				ip Code					of What Cou	intry?
	23a c	rai	15101 ALLISON F				1111				USA		
	tems items	une	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Dec If Yes, sp	edent of H ecify Cuba	ispanic Ori an, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates: \\	=	1 🗆 Yes	2 No	Specify:			Sp	pecify: WH	ITE
5-003	within 72 hours after deeth with the Maryland ene. then "naturel", or llems 23e or 28e-f ehow the Medical Exercinal recolling at	ted	15. Decedent's Ed		16a. Dece	dent's Us	ual Occup	ation during mos	t of worki	na	16b. Kind	of Business/I	ndustry
21215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired	1)	i or works	,,9	HOD	CE MD	ATNOD
	filed wi Hygien other th		17. Father's Name (First, Middle, Last)	ZYRS	HORS	SE T	RAIM		ar's Name	(First, Middle,	HOR Maiden Su		AINOR
Maryland	d a b	To Be	FRANCIS SMALL							E. WIL			
2		F	19a. Informant's Name/Relationship (7	ype, Print)		•				il Route Numbe			
	and 2 selth a m 27 le		MR. STEPHEN SMA					ON F		ONKTON			
ore	of He of He if Item or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	lace of Dispo emetery, crea	matory or	other plac			Date		tion - City or T	
Baltimore,	Peges tment of tant: If it		4 ☐ Donation 5 ☐ Other (Specify	GRE						4/05/0	6 BA	LTO.	CITY, MD.
Ba	permit. Peges 1 an Depertment of Heel Important: If Item 2 eny Injury or other <u>once.</u>		21. Signature of Funedal Service Licens	and !	H 1	ENR 692	Y W. 4 YO	<u>RK R</u>	KINS D MC	S & SOI	MD.	2111	
			23a. Part1. Enter the disease, or comp shock, or heart tailure. List only of	lications that caused the death one cause on each line.	n. Do not en	ter the mo	de of dyin	ng, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			Heart	Failus						24 hours
	/Medical Examiner		Todaking in obtain,	Due to (or as a consequ									24003
		er	Sequentially list conditions, if any, leading to immediate	b. Noc	mid uanea off:								270-3
V	outed id ansit	Examiner	Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c GI +	ract 61	000	120						3 years
Ó,	cate be executed bhysicien and the burial-transit		resulting in death) Last	Due to (or as a consequence		1 .		1450	.0	/	1 /	1.	3-1611
8760,	physic physic s the b	dical		d.	ele A	rthrid	UCHON	, Ma	llerms	hair of	The Co	[27]	24667
9 X	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregna	incy						230	d. Date of deli	very
Box	es that the death certific igned by the attending p be detached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of d		⊒Ectopic ⊒ Other (pregnancy specify)	/				Month	Day Year
P.O.	at the	hys	9 Unknown	9L] Unknown						1			d
	w requires the been signed should be de	Ď	Part II. Other significant conditions of		ulting in the u	underlying	cause giv	en in Part	i.		res 2 🗹		the cause of death?
Division of Vital Records,	@ S C1	Completed	Alzheime	elve replacement:						24a. Was autop perfo 1 Yes	rmed2	24b. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of
Ita	ysician: The l is certificete ha director, page	Be C	25. Was case referred to medical					26. Plac	e of Deatl	Check only o			20,10
>	Physici this ce al direc	10 E	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 🗆 (ursing Ho	me 5 Resid	dence 6	Other (Spec	ufy)
o uo	ding Pt. h. After the		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of M	28c. Injur Wor 1 🗆	yat nk? Yes 2. □		28d. Describe h	now injury o	occurred	
Jivisi	or Atten after dea Director in by the	Certification:	3 Suicide 6 Could not be determined			treet, tacto	ory, office			28t. Location (S City or Tox	Street and f vn. State)	Vum <i>ber or R</i> u	ral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical Ce		ysician: To the best of my kno niner: On the basis of examina and manner stated.									
	o the o the omple	Med	29b. Signature and title of certifier	and maining states.		2	9c. Licens	e number			29d. Date s	signed (Monti	n, Day, Year)
	- s + 3		122	11/11)		7	5395	-5-		4	-4-0	6
	127		30. Name and address of person who of BIMAL ASHAR M • I	completed cause of death (Item	n 23a) (Type) . S				THERVI	LLE,	MD 21	093.
		ate	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ture	del							
	Regist	rar	APR 0 5 ZUL	10 NOW MEN OF	0								

			for Stete Registrer	State	e of Mai		artment of Hertificate of L			iene g. No.	16	10513
	Diam'r.		1. Decedent's Name (First, Mic				0		2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medio		A57	BUR	\vee	\mathcal{N}	ムナーナ	H	MARCK		2006	7:55 AM
	Examir		4a. Facility Name (If not institut	ion, give street and	d number)		4b. City, Town, or	Location of Death		4c. County	of Death	
			Bon Secours				Ba1t	imore				
	Funeral		5. Social Security Number	6. Sex 1 X M 2 □		(In yrs. last birthda)) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpl	ace (State or Foreign
	Director		224-34-6953	IMM ZU	F	78 Yrs.			01-29-19		Virgi	
	D .		Usuel Residence of Decedent 10a, State 10b, Cour	th/		10c. City, Town or I	costion				14	Od. Inside City Limits
	ehow	-	Toa. State	,		roo. Oity, rown or i	COGLIOIT				1	1X Yes 2 □ No
	86-1 M	ctc	MD	NA NA			altimore					
	in the	Director	10e. Street and Number				10f. Zip Code		11	0g. Citizen of W	hat Coun	try?
	23a	Ta.	1010 W. Baltimo				2	1223		USA		
	72 hours after death with the Maryland neturel', or iteme 23a or 28e-f ehow disal Exaculter must be rustified at	Funeral	11. Marital Status	Arme	Decedent Every d Forces?	rer in U.S. 13	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America k, White, e	
36	or it	by Fu	1 Never Married 2 🕅 M	If Yes	res 2]∑]No s,Give		1 ☐ Yes 2 🕱 No	Specify:		Specify:		
8	72 hours neturel', ilical Exa		3 Widowed 4 Divorc		or Dates:						B1a	
21215-0036	72	Completed		ent's Education rest grade comple	ted)	(Giv	edent's Usual Occupa e kind of work done d DO NOT use retired.	uring most of work	ing	16b. Kind of Bu	siness/ind	lustry
12	within ene. then *	E G	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)) ""•.						
			17. Father's Name (First, Midd	e (ast)			Maintaina	nce 18. Mother's Nam	e (First Middle A			and Electric
Maryland	Q 22 D .	Be	Joe D. Smith	o, 2001)						naloon oomani	5/	
Ë	thould be id Menta marked matic ev	ဥ	19a. Informant's Name/Relation	achia (Tima Brias		10h Mai	ling Address (Street a	Maggie		C'2	O4-4- Ti-	0.41
Ma	12 sl h an 7 ie r traur				,							
	s 1 and 2 should f Health and Mer Item 27 ie marke other traumatic		Josephine Stith 20a. Method of Disposition	/ Wife		20b. Place of Disp	O W. Baltim	one Street	Baltimore,	M) 2122	Apt City or To	81()
ō	00-		1 🛛 Burial 2 🗆 Crematio		rom State	cemetery, cri	ematory or other place	9)		EUC. CUCATION	only of To	WII, State
Ë	tent tent		4 Donation 5 Other			Mt. Zion C		04-06-	06 I	ansdowne	, MD	
Baltimore,	permit. Pag Department Importent: I any njury c		21. Signature of Funeral Servi	\wedge			22. Name and Addres					
	40 = 4 O	2 .0	Surell	a you			Wylie Funera				o, MD	
	Physician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	ist only one cause	e to (or as a	PIRATI	ON PN	ひ互入つひり	U 1 A	,		Approximate Interval Between Onset and Death)
8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6.	e to (or as a 科ピア王 f	consequence of):	EBRO-VI		,			INKNOWA
u	e as	Me	IF FEMALE:	"						JE41 3	2 120	
.O. Box	The law requires that the death certificate hes been signed by the ettending I page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 🗆 L 4 🗆 P	s, outcome of ive birth 2 regnant at til Inknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mon	of delive	ry Day Year
σ.	s that	by P	Part II. Other significant cond	itions contributing	to death but	not resulting in the	underlying cause give	n in Part I.	23e. Did tob	acco use contri	bute to th	e cause of death?
g	uires n sign ild be	g D	- HYPE	RTENT	10N				1 🗆 Ye	s 2 🗆 No	3 🗌 Proba	ably 4 Unknown
င္ပ	w requir been si should	Completed	- CEREIS	DA NA	50113	412 3	1 < 2 = 0 : 4 =		24a. Was a	24h W	Jere autor	osy findings available
Be	The lay	Ę					732730		autops	y p ned? d	rior to con eath?	npletion of cause of
ā	ifficete or. pa			Hon!	からかさ	5 2			t ☐ Yes 2	1 No 1	☐ Yes	2 No
⋚	licie rect	Be	25. Was case referred to medi examiner? 1 ☐ Yes 2 ☐ No		~/		Othe	26. Place of Deat			1.011	
ō	Phys this ral di	5	27. Manner of Death		1 Plopatient Date of Injury	2 ER/Outpation		4 Nursing Ho	me 5 Reside 28d. Describe ho	nce 6 Othe	r (Specify)
5	ding I h. After funer	5	1 Natural 5 ☐ Pen	ding (Month, Day	Year) Injury	Work	? ′es 2 □No	200. Describe no	w injury occurre	3 4	
<u>si</u>	ttendi death. ctor: A y the fu	ical	3 ☐ Suicide 6 ☐ Cou	stigation d not be	Place of Injur	At home form		95 Z L 140	28f. Location (St	root and Mismbe	e o e Dueni	I Davida Aliverha
Division of Vital Records,	i or Attend after death Director:	Certification:	4 Homicide dete	mined 288. F	building, etc.	y - At home, farm, s (Specify)	treet, ractory, office		City or Town		n or nurar	Houle Number,
	dospite t hours uneral	Medical C	29a. Certifier 1 Certific (Check only one) 1 Medic	ai Examiner: On t	o the best of he basis of e manner state	xamination and/or i	th occurred at the tim	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and mar ate and place, a	nner as stand	ated. the cause(s)
	To the h within 24 To the f complete	Me	29b. Signature and title of cert				29c. License	number	25	d. Date signed	(Month, L	Day, Year)
)	->-0			Soll of	1 40	6	~ ~	7206		MAD	P 34 "	7. 2
•	\wedge		30. Name and address of person		00000 200	1)	D Z	2500	200/1	ITTE	-/ (2006
	11)		Ju. Name and address of person	wno completed	Tan 1	itn (Item 23a) (Type	Ani Ta	J DICEU	NES M	105 P.		212-3
			31. Date filed (Month, Day, Ye	21)-	32. Benistrar	s Signature	VV 15/12	1 7 2 1 '	101/2/	0 1771	<u>ر</u>	21223
	Sta Registr		31. Date filed (Month, Day, Ye	F 0000	giptidi	le 1	made 5					
DI	MH 17 Rev 1/2		APR U	5 2006	DEREN	J. J.S. Py						

NLM 06-02184 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kimberley Schnidt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician KIMBERLEY HOLLY SCHMIDT March 29,2006 9:48 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Route 140 East of Hughes Shop Road Westminister Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 217-82-9974 Director 11/20/1974 MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD Directo CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itете 23a or 2270 TYRONE RD. 21158 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 No Specify: WHITE þ 3 Widowed 4 Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING 12 permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: if Itam 27 is marked oth any july or other treumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARNOLD W. SCHMIDT, JR. CHRISTINE 19a. Informant's Name/Relationship (Type, Print) MOTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE M. SCHMIDT 2270 TYRONE RD. WESTMINSTER, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State ALL COUNTY CREMATION 3/31/06 SYKESVILLE, MD 4/☐ Donation _5 ☐ Other (Specify) 21. Synature of Fune of Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD.21157 Approximate Intervat Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple injuries **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of: Examiner Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 DUnknown 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No autopsy performed? certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}$ Mother (Specify) At Scene Medical Certification: To 1 ☐Xyes 2 ☐ No funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Driver of motor vahicle that collider 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 No 9:47 death. investigation 3-29-06 with another motor vehicle Director: / 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Route 140 East Hune Shoped Williamster M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide of ö Road within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) ZIXMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

. Registrar's Signature

Che Vision

LING

31. Date filed (Month, Day, Year)

APR 0 5 2006

O.C.M.E.

March 30, 2006

111 Penn Street Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician JACKIE EUGENE STONER 3, 2006 APRIL 2:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1058 OLD MANCHESTER RD. WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1⊠M 2□F 71 Yrs. Director 216-30-3002 MAY 18,1934 MARYLAND Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "nature!, or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 ☐Yes 2 X No WESTMINSTER Directo CARROLL MD10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1058 OLD MANCHESTER RD. USA 21157 12. Was Decedent Ever in U.S.

Armed Forces?

1 X Yes . 2 □ N KOREAN

If Yes, Give

Year or Dates: CONFLICT 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION permit. Pages 1 and 2 should be filed v
Department of Heelth and Mental Hygiel
important: if Item 27 is marked other 11
eny injury or other treumatic event, that 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE W. STONER LaRUE BARNES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 1 5 7 19a. Informant's Name/Relationship (Type, Print) 1058 OLD MANCHESTER RD., WESTMINSTER, - WIFE JOAN L. STONER 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a, Method of Disposition 1 QBurial 2 Cremation 3 Removal from State MEADOW BRANCH CEM. 4/6/06 WESTMINSTER, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Filippial Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ectal Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physicien end for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by the at id be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 📉 Residence 6 ☐ Other (Specify) ٩ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4/4/06 , M.D.

Westminster md.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

555 S.

32. Registrar's Signature

Center St.

ORIGINAL

Jaisatz M.D.

5 2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend #7&8 Per FH C856 6/09/06 JH Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0625 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Hospita Baltimore Cita Johns | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Pennsylvania) | Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1፟፟∭M 2□F 57 59 Yrs. 192-36-6204 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or iteme 23a or 28s-f ehow any highry or other treumatic event, the Madical Examiner must be notified at once. 28a-f ehow 1 No Yes 2 No Director Maryland Baltimore City 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 5911 Bonnieview Drive 21209 United States Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Chief Financial Officer Management Consulting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Ferree Eugene Clair Stein ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Stein /Sister 1735 Taylor St., N.W., Washington, D.C. 20011 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 3. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2006 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. lange te Car M013057557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonery Edema Physician 20 days /Medical Examiner Small Call Lung Canur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4 Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 & Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide

Box 68760, Division of Vital Records, P.O. Certification: To s after death.
I Director: After this of in by the funeral di within 24 hours a
To the Funeral C
completely filled pelli Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medicai and manner stated. To the 29b. Signature and title of certifier 29c. License number , Medical Doctor Res - 000 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keker + Suzil 74 John Hockin Hopital

31. Date filed (Month, Day, Year)

32. Ministrar's Singarum 600 North Wolfe Street, State APR 0 5 2006 Registrar DHMH 17 Rev 1/2001

		1	For State	State of	f Marylan		rtment of H		Mental Hy	giene Reg. No.	06	10517
			Registrar 1. Decedent's Name (First, Middle, La	ist)	0 1				2. Date of De		Year	3. Time of Death
	Physicia /Medic		Catherine	•	541	livan			Month 3	28	06	17.15pm
	Examin		ta. Facility Name (If not institution, gi	4 140 -	nber)		B	Location of Deat	re		y of Death	7
* 'SE'	Funeral Director). 	578-50-3237	Sex 1□M 2∏ F	7. Age (In yrs. 68	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bi (Month, Di 09/07/	ay, Year)	Cor	place (State or Foreign Intry)
	aryland ehow		Usual Residence of Decedent 10a. State 10b. County MD Howard			y, Town or Lo ridge	cation					10d. Inside City Limits 1 ☐ Yes 2 X No
	the M	recto	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	untry?
	3a or	o le	6706 Pirch Way				21075				USA	
9	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Iteme 23a or 28e-f show important: if Item 27 is marked other then "naturel", or Item 6 and 10	F	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo	2 X No	1	Was Decedent of H if Yes, specify Cub 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		ack, White	nican Indian, o, etc. nite
21215-0036	72 hours naturel', dical Exa	eted by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's I (Specify only highest g	Year or D	ates:	(Give	dent's Usual Occup kind of work done	during most of wo	orking	16b. Kind of		
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1	1-4or 5+)		ne Operat			Omni F	rint	
Maryland 2	d be filed antal Hygi sed other c event,	Be	17. Father's Name (First, Middle, Las Johnnie Davenport					18. Mother's Na Mildred	me (First, Middle Perry	e, Maiden Suma	ame)	
lary	and Me	ဥ	19a. Informant's Name/Relationship		1		ng Address (Street				n, State, Z	(ip Code)
e, G	s 1 end 2 if Health a Item 27 le other trau		Michelle Sullivar 20a. Method of Disposition	1 / Daug	20b. F	Place of Dispo	Pirch Way	- 1	Date	20c. Location	n - City or	Town, State
Baltimore,	Pages Iment of tant: If It jury or o		1 XBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	eity)	State	cwidge	Memorial F	ark 04/0	01/06	Elkric		
Ball	Departit Importany In		21. Signature of Funeral Service Lic			725	50 Washingt	on Blvd.,	Elkridoe,	MD 21075	ge Men	orial Park, INC
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that of yone cause on e	caused the deat	th. Do not en	n		ic or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to	(or as a consec	uence of):	eder	4				
, g	Examiner		Sequentially list conditions,	b	An (1713						
X	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	00010	Brain	Sint	4					
8760,	be exec icien an burial-tra		resulting in death) Last	Due to	(or as a consec	quence of):						
687	g physias the	edica		d		-						
O. Box	ne death certificate be executed the attending physicien and shed for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 ☐ Live I	atcome of pregn birth 2 ☐ Feta nant at time of c nown	aldeath 3[☐Ectopic pregnand☐ ☐ Other (specify)	у			Date of del Month	ivery Day Year
ds, P.O.	ulres that the de signed by the a Id be detached t	ρ	Part II. Other significant conditions	contributing to c	death but not res		underlying cause g		1	1 tobacco use co] Yes 2 □ No		the cause of death?
of Vital Records,	e law req hes beer je 2 shou	Completed							24a. Wa aut 1 2 Yes	topsy formed?	prior to death?	utopsy findings available completion of cause of
/ital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	,		100	bor	eath (Check only			
of	Phys r this ral di	To To	1 ☐ Yes 2 ☑ No 27. Manner of Death	160	Inpatient 2 of Injury nth, Day Year)	ER/Outpatie	INC 3 DOM	4 🗆 Nursing	Home 5 Re	sidence 6 ∐0 e how injury occ		icify)
ion	Attending Physic deeth.	ation	1 Natural 5 ☐ Pending investigation	tion	nth, Day Year)	Injury		ork?]Yes 2 □No				
Division	al or Attend effer deeth I Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Flac	e of Injury - At hiding, etc. (Spec	nome, farm, st ify)	treet, factory, office			(Street and Nu own, State)	mber or H	ural Route Number,
	To the Hospital or Attend within 24 hours effer deeth To the Funeral Director: completely filled in by the	edical C	29a. Certifier Check only one)	caminer: On the I	ne best of my kn basis of examin nner stated.	owledge, dea ation and/or in	th occurred at the nvestigation, in my	me, date and pla opinion, death oc	ce, and due to the curred at the tim	ne cause(s) and e, date and plac	manner as se, and due	s stated. e to the cause(s)
)	To th Within To th compl	Me	29b. Signature and title of certifier	MO			29c. Licer	se number 76435	415-11	3 Baltin	728/	th, Day, Year)
	b		30. Name and address of person w		use of death (Ite	m 23a) (Туре	Print) Reer	e Str	ef i	Baltin	rort	mp
100000	St Regist	ate trar	31. Date filed (Month, Day, Year) APR 0 5 2006	32.	Registrar's Sign	nature	٤					

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of He			iene	10518
K,	n ita		Decedent's Name (First, Middle, Las	1)				2. Date of Deat	h Day Year	3. Time of Death
1	Physicia /Medic	al	Charles	L.		Townes, J		April	1,2006	4.30 pm
	Examin	4.5	4a. Facility Name (If not institution, give	1 11 . 0	(0.)	4b. City, Town, or I	ocation of Death	Til.	4c. County of Death	n
- 33	<u> </u>		5. Social Security Number 6. Se		(In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	NA 9. Birth	hplace (State or Foreign
	Funeral Director		230-30-2971 M]M 2□F	76 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 2-2-30) Co	Md.
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla f shor	5	Md. NA		Balt	imore				1 X Yes 2□No
	with the Na or 28a-	I Director	10e. Street and Number 1812 E. 32nd St	reet		10f. Zip Code 21218	3	1	0g. Citizen of What Co USA	untry?
36	s 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "naturel", or iteme 23a or 28a-i' show other treumatic event, the Medical Examinat must be notified at	y Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent & Armed Forces? 1 XYes 2 N If Yes, Give	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp. , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	ture!	ed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:	16a. Dece	edent's Usual Occupa	tion		16b. Kind of Business/	Industry
215	in 72	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	life.	kind of work done di DO NOT use retired)	uring most of work	ing		_
212	filed within Hygiene. sther than "	Com	10th grade			s Delivery			Bob Davids	son Ford
Maryland	ld be filk ental Hy ked oth Ic event	To Be	17. Father's Name (First, Middle, Last) Charles	Lewis	Towne	es, Sr.	18. Mother's Name Lacie	e (First, Middle, I	Johnsor	n
Mary	2 should be f n and Mental h ls marked of reumatic ever		19a. Informant's Name/Relationship (Гурө, Print) Wife		ing Address (Street a. 2 E. 32nd	nd Number or Run	al Route Number Baltimo	; City or Town, State, 2	Zip Code) 1218
	of Health of Health if item 27		Charity Townes 20a. Method of Disposition		20b. Place of Disp	and the second second			20c. Location - City or	
Baltimore,	Pages ment of I tant: If its jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	·)		ll Bapt.	-		Blackstone	
Balt	permit. Page Department Important: II ony injury o		21. Signature of Funeral Service Licen	see War	ا کی	March F.H		Baltim 1101	ore, Md. 2 E. North A	
- 1	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Pheu	monia	nter the mode of dying	, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Examiner			b Luna	a consequence of):					
9	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Me+a	a consequence of):	to the	brain			
8760,	cate be executed physicien end the burial-transit	dical Exa	resulting in death) Last	Due to (or as	a consequence of):					
9	rtificati ng phy as the	Jedi	IF FEMALE:							
O. Box	The law requires that the death certificate be executed ate has been signed by the ettending physicien end bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
<u>α</u>	quires that the de n signed by the e uld be detached t	ed by Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlying cause give	on in Part I.		bacco use contribute to	o the cause of death? robably 4 Donknown
Division of Vital Records,		Completed by						24a. Was a autops perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of 2 \square No
/ita	vicien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Dear			
on of \	ding Phye	tlon: To	1 Yes 2 No 27. Manner ol Death 1 Natural 5 Pending investigation	28a. Date of Inju		of 28c. Injury Work	4		ence 6 □Other (Spe ow injury occurred	ecify)
Divisi	or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	_	jury - At home, larm, s ic. (Specify)	street, factory, office		28f. Location (S City or Tow	itreet and Number or R n, State)	ural Route Number,
1	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical Co	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	nysicien: To the best niner: On the basis of and manner st	I examination and/or	ath occurred at the tim investigation, in my op	ne, date and place, pinion, death occur	and due to the c rred at the time, c	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Med	29b. Signature an Atle of certifier	and manner st	atou.	29c. License	number	ž	29d. Date signed (Mon.	th, Day, Year)
	⊢ ≮ ⊢ ŏ		1 Kal.	Luch	han)	89	535		April 1.	2006
	10		30. Name an addr s of person who	completed cause of	death (Item 23a) (Typ	Macalant	Amora	1 Hosni	101	
100	St	ate	31. Date filed (Month, Day, Year)	32. Registr	rar's Signature	My y Iw	JUNIO	d loops	1001	
	Regist		APR 0 5 2006	Beales	15. A. 184					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stete Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day March 31, **Physician** 2006 2:40pm Terry Eartha /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nonths | Days | Hours | Min. | 7-30-64 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🖾 F Yrs. 41 Md. 218-80-2571 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Modical Examinar must be notified at 1 X Yes 2 ☐ No Baltimore Md. NA Be Completed by Funeral Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21218 1630 E. 25th Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 Is marked other than "natural", or Ite 1 ☐ Yes 2X No If Yes, Give Year or Dates: Never Married 2☐ Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Goodwin & Sons Seafood Wrapper 11th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jackson George 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 Is any injury or other trau 1630 E. 25th Street, Baltimore, Md. Franklin Reed Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, Md. King Mem. Pk. 4-6-06 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21202 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1101 E. North Ave. March F.H. East wane 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician oneumacu uneumonia. /Medical ficiency virus Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9. Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown 1 Yes 28 No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Tyes funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours en Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person

MD

Snite

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

CELER

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 19:57 PM 31 Thompson March 2006 Edward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NA Medical Center Dalto University of Mary land If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠**M 2□ F MD 217.66.4403 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or frems 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 □ No BALTIMORE Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4016 EDMONDSON AVENUE 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2**(**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION CAB DRIVER 9 TH GRADE permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other transpringury or other transmittle event, ILLS 00059. NIA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EDWARD THOMPSON, SR FORD MAREE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 EDMONDSON AVE E (MOTHER) MARKE THOMPSON BALTO. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State NATL 4 ☐ Donation 5 ☐ Other (Specify) 04.06.06 LAUREL , MO 21. Signature of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C- GREENE FUNERAL SERVICE Vaugan 5151 BAUTO NATU PIKE, BAUTO MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -48 hours EDS US /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 🗍 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 100 3 ☐ Probably 4 ☐ Unknown 1 Yes / hyperKalemia abnormalities 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?-Yes 2UNo 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) spital: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of Injury
(Month, Day Year) 28b. Time of Injury
(Month, Day Year) 28c. ٩ this After thi 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Division of Vital Records, P.O. Box 68760, within 24 hours after To the Funerel Dire

> State Registrar

31. Date filed (Month, Day, Year)
APR 9 5 2006

Ekbatani

29b. Signature and title of certifier

Greeke Street 22 South 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

March 31, 2006

29c. License number

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician A M April 3, 2006 Donald Lee Thompson 5:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 2, 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Director 213-36-1422 1937 Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow 1 ☐ Yes 2 X No Maryland | Montgomery Rockville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10404 Rockville Pike #101 20852 death United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Editor and Chief Trade Magazines permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, SINE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kenneth F. Thompson Nancy Lemen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth T. King/daughter 922 Wild Forest Drive, Gaithersburg, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 6. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Usensee Robert A. Pumphrey Funeral Home, Rockville, Inc 300 W. Montgomery Avenue, Rockville, MD 20850 William a. M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multilobax **Physician** DUENCEULO /Medical Due to (or as a consequence of): Examiner une to (or as on equence of): Sequentially list conditions sequentiam list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and s the burial-transit The law requires that the death certificate be executed rial librillation CUSSE Records, P.O. Box 68760. espiratory failure Completed by Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been si ONIEV 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ NO VO certificate has tirector, page 2 s of Vital Attending Physician: : After this certifical funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28c. Injury at Work? Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined within 24 hours after de To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Z Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DAILETEND 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) Doctori Drive Germanteun MD 20874 9529 200 fi 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

APR 0 5 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year STORMS TYLER 3:30 A. March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 718 N. Charles Street Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 90 Yrs. Months Days Hours Min. 8. Date of Birth (Month, Day Year) Nov. 26, 1915 9. Birthplace (State or Foreign Country) New York 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F Director 059-16-8456 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County oe filed within 72 hours after death with the Marylan al Hygiene d other then "naturel", or Hems 23s or 28s-1 ehow went, the Medical Examine must be notilled a 10d. Inside City Limits 1 Yes 2 □ No Director Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 718 N. Charles Street 21201 U.S.A. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 ☐Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 years Legal Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ie marked o 8 ဂ္ George Bernard Storms Bernadine McGarry 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ie m eny injury or other treum once. Barbara Tyler Ahlfield (daughter) 718 N. Charles Street Baltimore, Maryland 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverside Cemetery 4-8-06 Rochester, New York 21. Signature of Funeral Service Licensee Name and Address of Facility
Mitchell - Wiedefeld Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Lenus Approximate Interval Between Onset and Death

1 Month Physician Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, seating to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant etter for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, The law requires Atrial Fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Yes 2000No this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Yes 2XXVo Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: 28d. Describe how injury occurred 1 X X atural 5 Pending within 24 hours efter death.

To the Funeral Director: Al
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Modifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the natice(s) and manner as etated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D26534 March 31, 2006 hais Inhalment 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marc Sokolow MD 120 Sister Pierre Drive Towson, Md 21204 31. Date filed (Month, Day, Year), APR 0 5 2006 32. Registrar's Signature State Registrar

			1 - For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	artment rtificate				giene Reg. No.	06	10523
	Dhysisi		1. Decedent's Name (First, Midd	le, Last)						2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio		Dolores	Bernice	Unde	rwood				March	31	2006	8:35 A ^M
	Examir		4a. Facility Name (If not institution	n, give street and n	um <i>ber)</i>				ation of Death			nty of Death	
			Gilchrist Cer					timor				altimo	re
ľ	Funeral Director		5. Social Security Number 026-24-2875	6. Sex 1 ☐ M 2 🛣 F	7. Age (n yrs. last birthday 74 Yrs.			Jnder 24 Hrs. ours Min.	8. Date of Birtl (Month, Day NOV 9 ,	1931	Cou	place (State or Foreign intry) achusetts
	and		Usual Residence of Decedent 10a. State 10b. Count	,	1	Oc. City, Town or L	ocation						10d. Inside City Limits
	Aanyi Taho	5	MD Anne	Arundel		Harmans							1 X Yes 2 No
	the t	Pect	10e. Street and Number				10f. Zip C	ode			10g. Citizen	of What Cou	untor?
	Sa or	Funeral Director	7526 Harmans F	oad				1077			USA		indy:
	Jeath Tree 2:	era	11. Marital Status	12. Was Dec	cedent Ev	er in U.S. 13.			nic Origin? (Sp.	ecify Yes or No-		Race - Ameri	ican Indian.
336	72 hours after death with the Maryland natural; or Items 23a or 28a-f ahow Jical Examinat from the multified at	by Fur	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorce	II Van C	2⁴E4No iive		If Yes, specify 1 ☐ Yes 2 ☐	Cuban, M	exican, Puerto pecify:	Rican, etc.)	Е	Black, White,	
Ö	2 ho	Completed by		nt's Education		16a. Dece	dent's Usual (Occupation			16b. Kind of	f Business/In	ndustry
2	thin 7	ble	(Specify only night	est grade completed College	(1-4or 5+)	life.	DO NOT use	done during retired)	g most of work	ing			
7	or th	Son	12th	Ø		Own	er/Ope	rator			Dolor	ces' C	eramic Worl
р	d oth	Be (17. Father's Name (First, Middle,							e (First, Middle,		name)	
<u> X</u>	Men	ဥ	Joseph Miles							Talandg			
, Mar	and 2 shealth and 27 is mertrsum		19a. Informant's Name/Relation. Linda J. Georg		er					a/Route Numbe arel, MD			o Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23s or 28s-f ahow any injury or other traumatic event, the Medical Examiner ment be nullified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5)		1	20b. Place of Dispo cometery, cre MD Veter	matory`or othe	or place)	1	Date 2006	20c. Location	on - City or To	
Balti	permit. Departmine imports any inju		21. Signature of Funeral Service	Licensee	MO	2	2. Name and	Address of	Facility Do		Funer		me, P.A.
			23a. Part1. Enter the disease, o	mplications that	caused th							20707	Approximate
	Obvesiolom	k ()	Immediate Cause (Final	nly one cause on	each line.								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a		onsequence of):	UDST	100	70-6 6	ung di	SCASE		years
	Examiner			Due to	Olasac	onsequence on:							0
		Je.	Sequentially list conditions if any, leading to immediate	Due to	(or as a c	onsequence of):							
H	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	S									
o Í	exec en an rial-tr	Exa	resulting in death) Last	Due to	(or as a c	onsequence of):							
58760,	icate be executed physicien and s the burial-transit	edical		d	<u></u>								
89	rtifica ng ph	Med	IF FEMALE:	-1									
Division of Vital Records, P.O. Box	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within £4 hours alter death, within £4 bruns alter death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ TNo 9 □ Unknown		birth 2 (nant at tim	Fetal death 3	Ectopic preg					Date of delive Month	ery Day Year
٦.	that t ed by detac	/ Ph	Part II. Other significant conditi	ons contributing to	death but r	ot resulting in the u	nderlying cau	se given in	Part I.	23e. Did to	bacco use co	ontribute to the	he cause of death?
ords	w requires been sign should be	ted by	Biliny	cirrhos	is					1,52(1			bably 4 Unknown
Rec	The law ite has boage 2 st	Completed								24a. Was a autops perfor	med?	b. Were auto prior to co death? 1 \(\subseteq \text{Yes}	opsy findings available ompletion of cause of
<u>=</u>	ien: rtifica ctor, i	Bec	25. Was case referred to medica	ıt	-			26.	Place of Death	Check only or	222	100	2.3110
<u>_</u>	hysic lidire	2	examiner? 1	Hospital: 1	Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4	☐ Nursing Ho	me 5 Resid	ence 6 🔽	ther (Specif	m Hospice
o uo	nding PI ath. r: After the funeral		27. Manner of Death 1 Natural 5 Pending investing investing 5 1 Pending investing inv	'9	of Injury oth, Day Y	ear) 28b. Time o	f 28c	Injury at Work?		28d. Describe h	ow injury occ	curred	
Divis	al or Atte s after de il Directo id in by th	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Plac	e of Injury ling, etc. (- At home, farm, sti Specify)	eet, factory, o	ffice		28f. Location (S City or Town		mber or Rura	al Route Number,
	To the Hospital or Attending Physicien: The is within 24 hours after death, within 24 hours after death, to the Funeral Director: Alter this certificate he completely filled in by the funeral director, page	Ilcal	(Check only 2 Medical	ng Physicians. To th Examiner: On the t and mar	pasis of ex	amination and/or in	vestigation, in	my opinion	i, death occurr	ed at the time, d	ate and place	e, and due to	o the cause(s)
	To th To th Comp	Me	29b. Signature and title of certified		<i>'</i> 0		29c. L	icense num	nber	2	9d. Date sign	ned (Month,	Day, Year)
)			29b. Signature and title of certified and address of person 31. Date filed (Month, Day, Year APR)	My R	ly	h (Item 23a) /Tura	Print\	250	205	C	nm	ch 31	,2006
	1,7		W. A. R. Ley	63mc	676	Signatural :	line	es St	, Bal	to ms	21	207	
	Sta Registr	te ar	APR	5 2006	LAGA	S. J. J.	POSME						

DELONES UNDERWOOD 3/31/06

Amend item#26, perMD, G854, 4/5/06 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1 Decedent's Name (First, Middle, Last) March **Physician** 2006 26° Caroline Walraff Mabelle 9:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard Heartlands Assisted Living Ellicott City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sax 8. Date of Birth (Month, Day, Year) April 19,1913 Wisconsin 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F 92 388-07-9264 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan neal of Health and Mental Hygiene.
ant; if Item 27 is marked other than "naturel; or Items 23a or 28a-f ehow ury or other than ury or other traumatic event, the Moultain Examitter rest the routiling at 1 ☐ Yes 2x No Funeral Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 North Ridge Road U.S.A. 21043 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 K Widowed 4 □ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Education Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Goetter Caroline Merzdorf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 5070 Durham Road West Columbia, Maryland 21044 Lee Ann Hartman Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of important: if eny injury or once. Metro Crematory 3-29-2006 Catonsville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final theumonia Physician WELK disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): physicien Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No After this certification 25. Was case referred to medical 26. Place of Death (Check only one examiner? 6X Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No E Posidonco 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Medical 29a, Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWER 32 Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 5 State 2006 Registrar

			1 - For State Registrar	State of M	laryland		artmen <i>tificat</i>			ind M		giene	Jul	Pri Mitchionae	0525
	Physici		Decedent's Name (First, Middle, Last		an Ce	cilia	Witm	er			2. Date of De Month March	Day	y 2006	ear	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give						Location of	f Death			. County of	Death	7.51
1	LAGIIII	ie:	Holy Cross Nursin				Bur	tons	ville			Me	ontgo	nerv	7
۲ ,	Funeral		Social Security Number 6. Se	x 7. A	ge (In yrs. la	ast birthday)			If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	th			ace (State or Foreign
	Director		578-42-6554	⊒M 2 ∏ F	104	Yrs.	MOTILIS	Days	Hours		Jan 19		02 P		sylvania
	pu *		Usual Residence of Decedent 10a, State 10b, County		10c City	, Town or Lo	cation								0d. Inside City Limits
	eho eho	5					oution								1 X Yes 2 □ No
	the N	Director	MD Prince G 10e. Street and Number	eorge	Lau	reı	10f. Zip	Code				10m Cit	izen of Wha		
	with	2												at Cour	uy:
	ne 23	era	400 Talbott Avenu	E 12. Was Decedent	t Ever in U.S	3. 13.1		707	spanic Orio	nin? (Spec	cify Yes or No	U.S.	. A . 14. Race -	Americ	an Indian
ထ	4 within 72 hours after death with the Maryland liene. r then "netural", or Iteme 23a or 28a-f ehow the Medical Ezamaner mush be nadified at	Funeral	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 2 🔀	?	1	Yes, spec	offy Cubar	n, Mexican,	, Puerto F	Rican, etc.)		Black,	White,	etc.
8	ral', c	d b	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:			I ☐ Yes	ZOLJ NO	Specify:				Specify: W	hit	е
5	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ication le completed)		16a. Deced	kind of wo	k done d	uring most	of workin	ıq		ind of Busin		•
7	within iene. then	mpi	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT us	e retired))				ited S		es
2	ill Hygier other ti		12			Cler	<u> </u>		10 14-15-	de Nie este l	//: A # # #		vernme	ent	
Maryland 21215-0036	0 = 0 >	Be	17. Father's Name (First, Middle, Last)								(First, Middle	, маюел	Sumame)		
7	2 should be and Mental is marked sumatic ev	၉	John Mooney 19a. Informant's Name/Relationship (T	vna Print)		19h Mailir	n Address	(Street a	Mary		Route Numb	er City o	r Town St	ta Zin	Code)
∑	od 2 s Ith ar 27 is r trau			son							ırel, M				
ē,	f Hea	100	20a. Method of Disposition			ace of Dispo	sition (Nan	ne of	l l		ate		ocation - Cit		
Baltimore,	permit. Pages 1 and 2 should b Deperment of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic engines.		1 🛱 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		3	adowri	,		· 1	or 6	, 06	Dors	sey, N	larv	land
a H	mit. pertm ports / Inju		21. Signature of Funeral Servi - Licen	03/						-	Home, F				
m	Depe Impo	2 4	Miffere	h	M007								yland	207	07-4389
	Physician		23a. Part1. Enter the disease, or composhock, or heart failure. List only of Immediate Cause (Final	ne cause on each l	line.				g, such as o	cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Corona: Due to (or as	-		iseas	е							Years
	Examiner		Sequentially list conditions	b											
	, H	iner	Sequentially list conditions, if my leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	ence of:									
19	cate be executed physicien and the burial-trensit	Examiner		c. Due to (or as		assa of\:									
8760,	be ey	a E		D a a a a a a a a a a	3 4 00113044	Brice Or).								1/1	
687	ficate phys s the	dicai		d											
Вох	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date o	f delive	ry
ĕ.	the death certificate be executed y the attending physicien and iched for use as the buriat-trensit	Physician/Me	in the past 12 months? 1 Yes 2X No	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pr Other (sp						Month		Day Year
P.0	that the di ed by the detached	hys	9 Unknown	9 Unknown											
	es De	þ	Part II. Other significant conditions co	_		-		•							e cause of death?
ord	w requir been si should	ted	Atrial fibrillat	ion, Asth	nma, A	lzhei	ners	Dise	ase		10'	Yes 2	□No 3[] Prob	ably 4 ⊠Unknown
S	aw as b	Completed									24a. Was	an psy	24b. Wei	e auto	osy findings available
<u> </u>	Th ale pag	2										rmed? 2 ∏ No	dea 1 🗌		2 🗆 No
Vita	Physician: T r this certificat ral director, pa	Be	25. Was case referred to medical examiner?	-loopital:				Otha			Check only o				
ot	W 75	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inji		R/Outpatien 28b. Time of					e 5 Resident			Specify)
o	Afte	Ē	1 XNatural 5 Pending	(Month, Da	ay Year)	Injury	M	8c. Injury Work	al ? ′es 2 □ N	}	ou. Describe	now injui	у оссилва		
Division of	ten leal tor the	fica	3 Suicide 6 Could not be	28e. Place of In	ijury - At hor	ne, farm, str					8f. Location (Street an	d Number	or Rura	I Route Number,
ă	a after	Certification:	4 Homicide	28e. Place of In building, e	tc. (Specify))					City or Tox	wn, State)		
	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edicai (29a. Certifier 1 X Certifying Phy (Check only one)	sician: To the best iner: On the basis of and manner si	of examinati	vledge, death on and/or inv	occurred restigation,	at the time	e, date and inion, deat	d place, as h occurre	nd due to the d at the time,	cause(s) date and	and manne d place, and	er as st	ated. the cause(s)
	To the within 2 To the Complete	Me	29b. Signature and title of sertifier	0			290	. License	number			29d. Dat	te signed (A	Aonth, i	Day, Year)
ŀ	- > - 0		► 14 150R	Top	M			D23	181			Marc	ch 31,	, 20	006
	1,		30. Name and address of person who c	ompleted cause of	death (Item	23a) (Type,	Print)								
	(0		R. G. Bhojraj, M	.D. 704	Gorma	n Ave	T-1	, Laı	ırel,	Mary	yland 2	2070	7		
134	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 20		rar's Signati	yre do	asked								

Physi /Med		Decedent's Nan	mend Item ne (First, Middle, Las e Wajer		0 101 111					2. Date of D Month March	27, Day 2		3. Time of Death 5:42 PM M
Exam			(If not institution, give aware Ave		')		4b. City, Town, Essex	or Location	of Death			County of Deetl	
Funera Directo		5. Social Security 213-34-	Numb etinl 6. S 2685		ge (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of B (Month, D	irth (ay, Year)	9. Birth	nplace (State or Foreign untry) yland
aryland show	_	Usual Residence of	10b. County Baltimo		10c. City, Tow	m or Loc							10d. Inside City Limits
death with the Maryland ms 23a or 28e-f show rmust be notified at	Director	MD 10e. Street and No.				E55	10f. Zip Code	1221			-	en of What Co	
ㅎ 욕됨	by Funeral	11. Marital Status 1 ☑ Never Mar 3 ☐ Widqwed	ried 2 Married 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	:?] No		Was Decedent of Yes, specify Cu	Hispanic C ban, Mexic		ecify Yes or N Rican, etc.)	lo- 14	4. Race - Ame Black, White Specify: Wh	e, etc.
within 72 hours atter ene. then "naturel", or Ite	Completed	(Spec	15. Decedent's Eacify only highest gra condary (0-12)	completed) College (1-4or		(Give life. L	lent's Usual Occi kind of work don OO NOT use retir	e during mi	ost of work	ing		d of Business/	·
I be filed wintal Hygien ed other the	Be	17. Father's Name	(First, Middle, Last,	0		bu	yer			e (First, Middi	e, Maiden S		lectric
2 should be and Mental	70	19a. Informant's I	Name/Relationship (g Address (Stree	et and Num	ber or Run	al Route Num	ber, City or		Zip Code)
Permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. In moortant: If item 27 is marked other than "natural", or my injury or other treumatic event. The Medical Examination.		20a. Method of Di 1 Burial 2 1 Donation	Cremation 3 C 5 Other (Epocial	Removal from State	20b. Place o cemete	of Dispos ory, cren	Boston sition (Name of natory or other pi Cremator	lace)	4/07	Date /2006	20c. Loc Balt	21222 ation-City or cimore	MD
permit. Page Department o Important: If any injury or	SUCE.	21. Signature of I	Uneral Service Lices	Warde, Di	OMOr.	22	. Name and Add	ress of Fac	lityKac	zorwsk	i Fune	ral Ho	
			610001	11/1	Tel -	Ba	ltimore	, MD	-2120	±21222	1201	Dunda	lk Ave.
Physicia /Medica	al 💮	23a. art1. ter shock, on te Immediate Cause disease or condit resulting in death	ion	a Anterio	ed the death. Do line.	not ente	ltimore	• MD ying, such a	2120 as cardiac	±21222	1201 arrest,		
/Medica Examine	al F	Immediate Cause disease or condit resulting in death	(Final ion) conditions, immediate serving or injury	Due to (or a	sclentic	not enter	ltimore er the mode of dy	• MD ying, such a	2120 as cardiac	±21222 or respiratory	1201 arrest,		Approximate Interval Between Onset and Death
(e be executed hylician and purish transit e burial-transit	cal Examiner	Immediate Cause disease or condit resulting in death Sequentially list of lianty, leading to cause. Enter Uncause (Disease othat initiated even resulting in death	(Final ion) conditions, immediate serving or injury	Due to (or a	sclentic s a consequence	of):	ltimore er the mode of dy	• MD ying, such a	2120 as cardiac	±21222 or respiratory	1201 arrest,		Approximate Interval Between Onset and Death
death certificate be executed death certificate be executed e attending physician and dor use as the burial-transit	cal Examiner	Immediate Cause disease or condit resulting in death Sequentially list of lianty, leading to cause. Enter Uncause (Disease othat initiated even resulting in death	onditions, immediate derlying or injury its) Last	b. Due to (or a c. Due to (or a d	s a consequence	of):	ltimore er the mode of dy	,MD yying, such a ならこし	2120 as cardiac	±21222 or respiratory	1201 arrest,		1k Ave. Approximate Interval Batween Onset and Death
ss that the death certificate be executed with the death certificate by executed many gned by the attending physician and be detached for use as the burial-transit	by Physician/Medical Examiner	Immediate Cause disease or condit resulting in death Sequentially list of any, reading to cause. Enter Unc Cause (Disease of that initiated even resulting in death IF FEMALE: 23b. Was decede in the past 1 1 □ Yes 2 9 □ Unknow. Part II. Other sign	onditions, immediate derlying or injury its) Last	a. Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	is a consequence is a consequence is a consequence in of pregnancy 2 Fetal death at time of death	of):	Itimore or the mode of dy over the mode of dy	,MD yying, such a ならこし	-2120 as cardiac	121222 or respiratory	1201 arrest, @SQ	Dunda 3d. Date of del Month	Approximate Interval Between Onset and Death Control of the Control of the Control of the Control of the Cause of death?
The law requires that the death certificate be executed at the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medical Examiner	Immediate Cause disease or condit resulting in death Sequentially list of any, reading to cause. Enter Unc Cause (Disease of that initiated even resulting in death IF FEMALE: 23b. Was decede in the past 1 1 □ Yes 2 9 □ Unknow. Part II. Other sign	onditions, immediate derlying in injury is) Last	a. Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	is a consequence is a consequence is a consequence in of pregnancy 2 Fetal death at time of death	of):	Itimore or the mode of dy over the mode of dy	,MD yying, such a ならこし	-2120 as cardiac	239. Did	1201 arrest, @SQ tobacco us Yes 2 us an opsy tormod?	Ounda 3d. Date of del Month se contribute to No 3 pr	Approximate Interval Batween Onset and Daath O Y WAN ivery Day Year o the cause of death? obably 4 Wunknown utopsy findings available completion of cause of
sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and riector, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	Immediate Cause disease or condit resulting in death resulting in death Sequentially list of any, leading to cause. Enter Unit Cause (Disease of that initiated even resulting in death I Sequential S	conditions, immediate berying or injury its 1 Last 2 months?	Due to (or a b. Due to (or a c. Due to (or a d	is a consequence is a c	of): of): in the unupatien	Ectopic pregnan Other (specify)	MD yying, such a ying, such a ying, such a ying, such a ying a given in Pal	2120 as cardiac	23e. Did 24a. What per la La Yes th (Check only)	1201 arrest, (US) 1 tobacco us] Yes 2 [us an opsy formed? 2 [us one) sidence 6	3d. Date of del Month se contribute to Prior to death? 1 Yes	Approximate Interval Batween Onset and Death Conset and D
yeician: The law requires that the death certificate be executed sis certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	o Be Completed by Physician/Medical Examiner	Immediate Cause disease or condit resulting in death resulting in death Sequentially list of any, leading to cause. Enter Unit Cause (Disease of that initiated even resulting in death I Sequential S	onditions, immediate berying or injury its last via the conditions of the conditions	Due to (or a b. Due to (or a c. Due to (or a d. 23c. If yes, outcom 1	is a consequence 2 Fetal death at time of death but not resulting i	of): of): of): utpatien Time of Injury	Ttimore er the mode of dy Color of the mode o	ying, such a ying a ying a ying a ying a tork?	as cardiac COL	239. Did 24a. Water per la	1201 arrest, 23 d tobacco us Yes 2 as an opsy formed? 2X No v one) sidence 6 e how injury	Dunda 3d. Date of del Month se contribute to prior to death? 1 Yes	Approximate Interval Batween Onset and Death Conset and D

State Registrar

30. Name and address of person who completed cause of peath (Item 23a) (Type, Print)

Philip Militallo MD (Trimble Hill CT, Lutherville MI)

31. Date filed (Month, Day, Year)

APR 0 5 2006

	7.34		1 - Stata Registrar	State of Maryl			t of Health ar e of Death	2. Date of D	Reg. No.		0 5 2 7
7	Physici		Decedent's Name (First, Middle, La	Si)			Wright	Month APRII	Day	Year 2006	1505PM
2.	/Medic Examin		Helen 4a. Facility Name (If not institution, gire	re street and number)		4b. City,	Town, or Location of			unty of Death	
*			GOOD SAMARI	CAN HUSPIT	AL	Ba	-110				
	Funeral Director		-	Sex 7. Age (In) 1□ M 2/□ F 7.2	Yrs. last birthday) Yrs.	If Under Months		Min. (Month, D	rth a <i>y, Year)</i> 26 33	Countr	ce (State or Foreign y) A
	land ow		10a. State 10b. County	10c.	City, Town or Lo	cation		-		100	d. Inside City Limits
	Mary Figh	tor	MD NA	E	Baltimo	re					1 Yes 2 □ No
	th the)irec	10e. Street and Number			10f. Zip				of What Countr	y?
	ath wi	rai	5607 Clearspri	·			21212			J.S.A.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show other traumatic event, the Medical Exams are must be codified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married XWidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deced f Yes, spec 1 ☐ Yes	dent of Hispanic Origin offy Cuban, Mexican, I 2 No Specify:	n? (Specify Yes or N Puerto Rican, etc.)		Race - Americal Black, White, et recify: Bla	c.
ဝို	72 hou	Completed by	15. Decedent's E (Specify only highest gr		16a. Dece	ient's Usua	al Occupation	of working	16b. Kind	of Business/Indu	stry
2	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT us	se retired)	working	D		
12	iled w tygier her th		10th grade 17. Father's Name (First, Middle, Las.	na	Do	mest		s Name (First, Middle	1	ivate	
Maryland	ould be fi Mental H arked ot atic ever	Be							e, Maiden Su	mame)	
2	should and Men a marke umatic	ဥ	Roosevelt Camp 19a. Informant's Name/Relationship		19b. Mailir	ng Address	(Street and Number	a Scott or Rural Route Numi	per, City or To	own, State, Zip C	ode)
Ž	s 1 and 2 s of Health ar item 27 is other trau		Brenda Anderso	n-Daughter	5607	Cle	arspring	Rd, Bal	Ltimor	e, Md	21212
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2' any injury or other in	10 - 31	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [b. Place of Dispo cemetery, crer	sition (Nan	ne of hther place)	Date	20c. Locat	ion - City or Tow	n, State
Ĕ	Pag ment ant: h		4 Defration 5 Other (Speci		ing Mem	oria	l Park 4	/7/06	Rand	dallsto	wn, Md
<u>3alt</u>	Departit.		21. Signature of Funeral Service Lice	nsee '\ (n=0)			d Address of Facility F/H West	x			
	40240	1-1	232 Part Enter the disease or con	Ti Sha yayard the caused the c	43	00 W	labash Av	e, Balt:	more		ZIZI5 Approximate
			23a. Part Enter the disease, or con show, or heart failure. List only Immediate Cause (Final								nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a con		CF	RDIOM	190 PAT	НЧ	-	
	Examiner			ATHEROSI		C	VASCULA	R DISE	ASE		
7	P ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):						-
~	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C							
60,	be ex iclan burial		1	Due to (or as a con	sequence or):						
68760,	tificate be executed ig physician and as the burial-transit	edical		d							
Vital Records, P.O. Box (Attending Physician: The law requires that the death certir death. r death. ector: Atter this certificate has been signed by the ettending by the funeral director, page 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pr Othar <i>(sp</i>			23d	l. Date of delivery Month D	, Day Year
ם.	that hed by deta	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying c	ause given in Part I.	23e. Did	tobacco use	contribute to the	cause of death?
g	quires in sign	q pe	CONGESTIVE	HEART FA	HLURE	EN	STAKE	1	Yes 2	lo 3 🗆 Probab	oly 4 □Unknown
000	aw requir ts been si 2 should	Completed	KIDNEY DIS	EASE				24a. Wa	s an 2	4b. Were autops	sy findings available of
œ e	The late has	E						per 1 Yes	ormed?	death?	
ita ita	cian: ertifica	Be	25. Was case referred to medical examiner?					f Death (Check only			
<u>></u>	hysic this co	P	1 ☐ Yes 2 12 No		2 ER/Outpatier			ing Home 5 Res			
Z C	ling P	ion:	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury		8c. Injury at Work?	28d. Describe	how injury o	ccurred	
Division of		Certification:	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	e George of Injury	At home, farm, str	M eet, factory	1 Tes 2 No	28f. Location	(Street and Nown, State)	lumber or Rural i	Route Number,
	ital or its aft ral Di										
	To the Hospital or within 24 hours after To the Funeral Dit completely filled in	Medicai	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death nination and/or in	occurred vestigation	at the time, date and and in my opinion, death	place, and due to the occurred at the time	e cause(s) an , date and pla	d manner as stal ace, and due to t	led. he cause(s)
	Mithin Fo the	Me	29b. Signature and title of certifier				: License number		29d. Date s	igned (Month, Di	
			Stuti Sh	ankar N	10	F	Res 00	0	APR	1 1	2006
45-	b		30. Name and address of person who	completed cause of death (Item 23a) (Type	Print) OCH	RAVEN	1 BLVD	BAL	TIMORE	MD-2123
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's S	ignature	A. D.					

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar	State of Maryland		artment of H rtificate of L			giene Reg. No.	06	10528
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
Physiciar /Medica	П	Marian Williams					March	30	2006	
Examine		la. Facility Name (If not institution, give s	/\ /:	ما م	4b. City, Town, or	Location of Death		4c. Cou	nty of Deat	~^
		Johns Hokins Box 5. Social Security Number 6. Sex	7. Age (In yrs. las	Her	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	<u>Da</u>		hplece (State or Foreign
Funeral Director			M 2⊠F 71	Yrs.	Months Days	Hours Min.	(Month, Da)	y, Year)	Co	untry) MD
D	-	Usuel Residence of Decedent	/#							
arylan show		10a. State 10b. County		Town or Lo						10d. Inside City Limits XIXYes 2 □ No
he Ma	Director	MD NA	Ba.	ltimo	10f. Zip Coda			10g. Citizen	of What Co	
with t		10e. Street and Number				215		•	S.A.	•
death	runeral	2524 Keyworth A	2. Was Decedent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No		Race - Ame	rican Indian,
or Iter	2	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 3(□XNo If Yes, Give	i	ifYes, specify Cuba 1 □ Yes 2 🔯 No	n, Mexican, Puero Specify:	Hican, etc.)		Black, White	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than 'natural', or items 23e or 28e-f show out, the Macinal Examiner must be notified at	d D	3 ☐ Widowed 【★★Divorced	Year or Dates:						, Б	lack
72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of world	king	16b. Kind o	f Business/	Industry
withir than	E C	Elementary/Secondary (0-12)	College (1-4or 5+)		rmacist	,		Unive	ersit	y Hosp.
d 2 Hygie other	De C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden Sun	name)	
ylan, outd be Mental arked o	0	Harvey Demby				Nannie	Morris	,		
Maryland d 2 should be file th and Mental Hy i7 is marked oth treumatic event		19a. Informant's Name/Relationship (Typ			ng Address (Street a					Zip Code)
ore, M s 1 and 2 of Health Item 27 i	-	<u> Laleta Williams</u>			Keywort	h Ave,	Baltin Date			21215
Pages 1 annent of Heal	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ R	emoval from State	netery, crei	nsition (Name of matory or other plac					Town, State
다 등 등 구	-	 4 □ Donation 5 □ Other (Specify) 21. Signature of Fugeral Service License 			norial F		1/06	Randa	llst	own, Md
permit. Departri Imports eny inju		21. Signature of Funda Service Eldense	K. Im	Ma	arch F/H	West	Dol+i	m 0 M 0	Ма	21215
	+	23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death.	Do not en	300 Waba er the mode of dyin	g, such as cardiac	or respiratory a	rest,	rid	Approximate Interval Between
Physician		Immediate Cause (Final	40		//	Heral 1	0 = 0			Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a conseque	nce of):	01/W)	rike 1.	95			marks
Examiner		Sequentially list conditions, b	perioher		voscular	disea	se			years
p ii e	lue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duel to (or as a conseque	ince of):						/
wecute and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ince of):						
58760, ficate be executed physician and s the burial-transit	dical E									
687 tificate ig phys as the	Φ –							T		
Box 6 eath certification attending	2	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of		Ectopic pregnancy			23d.	Date of del	,
O. B.	SICIA	in the past 12 months? 1 ☐ Yes 2 ☒ No	4 Pregnant at time of dea		Other (specify)				Month	Day Year
P.O. that the de ed by the detached	Physician/M	9 Unknown				an in David	220 Did t	abanan usa s	ostábuto to	the cause of death?
S the set the	^	Part II. Other significent conditions con	(Li-Li) c	ung in the t	inderlying cause give	enin ranti.	1 🗆 1			obably 4 Unknown
Records, he taw requires to the taw requires to the taw been signed age 2 should be	Completed	diabetes mel	717-3				24a. Was			itopsy findings available
Rec	E					····	autor	rmed?	prior to death?	completion of cause of
		25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2 No	1 ∐ Yes	2 □ No
- 09 =	o Re	eyaminer?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie	nt 3 DOA Oth	79392	ome 5 Resid		Other (Spe	cify)
O E = a '	<u></u>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injun	y at	28d. Describe			
endir endir or: Af	Satio	1 Natural 5 Pending 2 Accident investigation			M 1 🗆	Yes 2 □ No				
or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (: City or To		ımber or Ru	ural Route Number,
Vision of the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th combletely filled in by the funeral		29a. Certifier Certifying Phys	sicien: To the best of my know	ledne dost	h occurred at the tin	ne date and nlace	and due to the	rause(s) and	manner as	stated
To the Hospital within 24 hours of To the Funeral is completely filled	Medical	(Check only 2 Medical Examinations)	ner: On the basis of examination and manner stated.	on and/or in	vestigation, in my o	pinion, death occu	rred at the time,	date and pla	ce, and due	to the cause(s)
Within To the compl	Z e	29b. Signature and title of certifier	10 1		29c. Licensi	e number		29d. Date sig	gned (Mont	h, Day, Year)
		My ble + Kill	lester m	0	PS.	33/6		3-	31.	-06
1)		30. Name and address of person who co	mpleted cause of death (Item :	23a) (Type,	Print)	1. 17.		- /2	/	Dillo
		Michael F. B	effection M.	0 5	505 00	Kins B.	y Wen	6/1	ry/c	Bulteman
Stat Registra	-	3¶. Date filed (Month, Day, Year) APR 0 5 2006	32. Registrar's Signatu	600A	E)					MDZIZZY

ase	rype of Fillit in black indelible link.	. Ensure All Copies Are Legibi
	State of Maryland / Department of F	lealth and Mental Hygiene 🗍 🗍

D				1 louse					Health and	•		9		1520
			T = For State Registrar			,		rtificate of			Reg. No			ال سال ل
	Physici	an	1. Decedent's Nam			kerso	n			Date of De Month	Da			ime of Death
	/Media	al	Kevin Eric Wilkerson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location				or Location of Deat	MARCH		31, 2006 4c. County of Death		02 P. ^M		
	Examir	er	SOUTHERN MARYLAND HOSPITAL CLINTON							PRINCE GEORGES				
	Funeral		5. Social Security N	lumber 6.		Age (In yrs.	**	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Bir (Month, Da	+h	0.5		State or Foreign
	Director		214-92-6	-92-6186 4-27-1965 Mar								ry1a	nd	
	/land		10a. State	10b. County		10c. City	y, Town or Lo	ocation					10d. Ins	ide City Limits
	r 28a-f show	ctor	MD	Prince	Georges	Up	per M	ar1boro)				11/2]Yes 2 □ No
	長の質	Funeral Director	10e. Street and Nu					10f. Zip Code 20772				S.A.	Country?	
	eath w	erai	9600 Mea	adowlar	12. Was Decede	ent Ever in II	S 13			Decify Ves or No		14. Race - Ar	neocan Indi	ian
ဟ	or Item	Fun		ied 2[X]Married	Armed Force	s?			Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)		Black, W	nite, etc.	
21215-0036	ours a	d by	3 Widowed	4 Divorced	If Yes, Give Year or Date	os:		1 □ Yes 2 □ x No	Specify:			Specify: I	зтаск	-
15-(n 72	lete	(Spec	15. Decedent's E cify only highest g	ducation rade completed)		16a. Dece (Give	dent's Usual Occu kind of work done	ipation a during most of wo ad)	rking	16b. F	(ind of Busines	s/Industry	
212	J within Jiene. r then "	Completed	Elementary/Seco 12	ondary (0-12)	College (1-4	or 5+)		icator	50)		P	rivate	2	
pu	be filed wi	Bec	17. Father's Name	(First, Middle, Las	t)				18. Mother's Na	me (First, Middle	, Maidei	Sumame)		
Maryland	Men	7	Roy Will							e Warr				
Mai	d 2 sho th and 7 Is my treum		19a. Informant's Na	·				_	tand Number or Ri Jark Dr		-			20772
	of Health of Health Item 27 I		Maris W: 20a. Method of Dis	position			lace of Dispo	sition (Name of matory or other pla		Date		ocation - City		
E G	Page nent o int: If iry or			☐Cremation 3 5 ☐ Other (Spec	□Removal from Sta ify)	ite .	-		cem. 4-	11-06	C 1	inton	Marv	land
Baltimore,	permit. Pages Department of I Important: If It eny injury or of		21. Signetture of Fa	moral Service Lice	ensee	1.50	2:	2. Name and Add	rshedia i	aylor,	II	Funera	al Ch	ape1
	405 a		7). (U a	W01				ld1eport			Plair		
			shock, or hea	in failure. List on	nelications that cau	h line.				or respiratory a	rrest,		Interv	ximate al Between and Death
	Physician /Medical		disease or condition resulting in death)	on a	a	as a consequ	uence of):	njuvis						
	Examiner		Sequentially list co	nditions	b									
	ed sit	Examiner	Sequentially list co if any, loading to in cause. Enter Unde Cause (Disease or	orlying Injury	Dua to (or	at a ourieudi	uenee of):							
Ć.	be executician and burial-tran	Exan	that initiated events resulting in death) I	5	c. Due to (or	as a consequ	uence of):						-	_
760,	0 4 0	cai		•	d									
89 X	leath certificat attending phy I for use as th	Med	IF FEMALE:											
Вох	ath ca	lan/	23b. Was decedent in the past 12	months?		me of pregna n 2 ∏ Fetal tal time of de	death 3[Ectopic pregnand	су			23d. Date of d Month	elivery Day	Year
0	that the de led by the s detached t	nysk	1 ☐ Yes 2 ☐ 9 ☐ Unknown		9☐ Unknow		Jakii 3	Other (specify) _						
S, P	res that igned to be det	by Physician/Med	Part II. Other signif	ficant conditions	contributing to deat	h bul not resu	alling in the u	nderlying cause g	ven in Part I.	23e. Did t		use contribute	lo the caus	e of death?
ord	w requires been signi should be									10	Yes 2	M(No 3□	Probably	4 □Unknown
of Vital Records,	has has	Completed								24a. Was autop		24b. Were prior to death	comptetion	dings available n of cause of
<u>la</u>	ician: Th certificate ector, pag		25. Was case refer	red to modical						1 Yes	2 🗆 No			0
N N		To Be	examiner?		Hospital:	atient 2 🏋	ER/Outpatier	I 3□ DOA Ot	hor	ath <i>(Ch</i> eck only d Iome 5 ☐ Resi		6 ∏Olher /Sr	necify)	
0	ding Phys h. After this funeral di		27. Manner of Deat		28a. Date of I	- 71	28b. Time o			28d. Describe motocac	how inju			4v02
Division	ttending death. tor: After the funer	catio	2 Accident	investigation	3 31 0		Found 3:	13 M 10	Yes 2 No	0				
Div	l or Al after d Direc	ertifi	4 Homicide	determine	28e. Place of	elc. (Specify	me, farm, sti	eet, factory, office		28f. Location (: City or Tox	wn, State	1088 1	Fran	Number, K Tippett
	pspite hours uneral y filled	SalC	29a. Certifier	1 Certifying P	hysicien: To the be	st of my know	wiedge, deat	occurred at the t	ime, date and place	and due to the	cause(s) and manner	as stated	
	To the Hospitel or Attsndi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	(Check only		miner: On the basis	s of examinat	ion and/or in							
	Con Con	~	29b. Signature and	title of certifier	mil				se number			te signed (Mo		ear)
,	4		30. Name and addr	ess of person who	completed cause of	of death (Item	23a) (Type		.M.E.		APRI	L 1, 20)06	
(7		L1N4		ant		. 202/ (1990)	-	N STREET	BALTIMO	RE,	MARYLAI	ND 212	201

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month PR 07) 5 2006

			1 - For State Registrar	otato of many tare		artment of Health and rtificate of Death		eg. No.	10000
	Physici	an	Decedent's Name (First, Middle, La		HIEL	WYAND	2. Date of Deat Month	Day Year	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution, given			4b. City, Town, or Location of Dea	APRIL 1	1 , 2006 4c. County of Dea	
			COUNTRY COMPA	ANIONS		TANEYTOWN		CARROLI	- -
	Funeral Director		064-28-7149	Sex 7. Age (In yrs. 1 ☐ M 2 ☑ F 7 1	last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day,	Year) C	rthplace (State or Foreign ountry) N YORK
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation			10d. Inside City Limits
	ath with the Marylan 23a or 28a-1 ehow ust be notified	ctor	MD CARRO	OLL	SYKES	SVILLE		1 ☐ Yes 20 No	
	or 28	Director	10e. Street and Number			10f. Zip Code	1	0g. Citizen of What C	ountry?
	sath w		117 HERITAGE	7	C 10	21784	C	USA	oriena ladina
36	hours after death with the Maryland tursi', or Itams 23a or 28a-f ehow at Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic Origin? (. If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	14. Race - Am Black, Whi	
2-0036		ted	15. Decedent's E (Specify only highest gr	Education	16a. Dece	dent's Usual Occupation kind of work done during most of wo	orking	16b. Kind of Business	
7	within 72 ene. then "na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	Jiking	HOME MA	V E D
22	filed w Hygier other tl		17. Father's Name (First, Middle, Lasi	<i>t</i>)		HOUSEWIFE	me (First, Middle, M		KEK
Maryland	e d in D	To Be		ERMAN CARL	THIEL		LISLE H		
ary	should and Men s marke umatic	-	19a, Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street and Number or F	lural Route Number	; City or Town, State,	Zip Code)
	and 2 Balth a n 27 Is		SIEGFRIED WOOD			HERITAGE LANE,			
altimore,	Pages 1 and ment of Healint: If Item 2 ary or other		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	Removal from State	semetery, crer	estion (Name of matory or other place)		20c. Location - City o	
	nit. Pa artmen ortant: Injury E.		4 □ Donation 5 □ Other (Special Signature) Foneral Service Lice			Y CREMATION 4. Name and Address of Facility F1		SYKESVII	
Ba	Depa Impo		1	11355		54 E. MAIN ST			MD 21157
			23a. Pa/t1. Enter the disease, or construct, or heart failure. List only	nplications that caused the death y one cause on each line.		er the mode of dying, such as cardia	ac or respiratory arre		Approximate Interval Between Onset and Death
è	Physician /Medical		disease or condition resulting in death)	a. Cereleron	use	uly accord	int		1 uch
	Examiner								
	LXdillillet			Due to (or as a consequence)	uence of):			Quem	2021
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Oue to (or as a consequence of the consequence o	sele		lm 1	Prsease	257
		xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.	uence of):			Prsease	25y
,09,		sal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. artern	uence of):			Piseare	10 yr
68/60,	icate be executed physicien and the buriat-transit	edical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.	uence of):			Piseare	25y
Box 6	death certificate be executed e attending physicien and of for use as the burial-transit	edical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 M No	Due to (or as a consequence.	uence of): uence of): ancy I death 3 [23d. Date of de Month	257 2017 2017 2017 2017
P.O. Box 6	death certificate be executed e attending physicien and of for use as the burial-transit	Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or as a consequence) c. Que to (or as a consequence) d. 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of degree Pr	uence of): ancy I death 3 [leath 5 [Description of the Control of the Co	lm 10	23d. Date of de Month	
P.O. Box 6	death certificate be executed e attending physicien and of for use as the burial-transit	by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	b. Due to (or as a consequence) c. Que to (or as a consequence) d. 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of degree Pr	uence of): ancy I death 3 [leath 5 [Description of the Control of the Co	lm 10	23d. Date of de Month	Day Year
P.O. Box 6	requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	b. Due to (or as a consequence) c. Que to (or as a consequence) d. 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of degree Pr	uence of): ancy I death 3 [leath 5 [Description of the Control of the Co	23e. Did tot 1	23d. Date of de Month Dacco use contribute les 2 Mo 3 F	Day Year to the cause of death? Probably 4 Unknown
Hecords, P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown	b. Due to (or as a consequence) c. Que to (or as a consequence) d. 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of degree Pr	uence of): ancy I death 3 [leath 5 [Description of the Control of the Co	23e. Did tot 1 Ye 24a. Was ar autops perform	23d. Date of de Month Dacco use contribute les 2 Mo 3 Fen prior to feath?	Day Year to the cause of death? Probably 4 Unknown uutopsy findings available completion of cause of
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Jane 9 Unknown Part II. Other significant conditions.	b. Due to (or as a consequence) c. Que to (or s a consequence) d. 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal 4 Pregnant at time of degree Pre	uence of): uence of): ancy I death 3 [eath 5 [Description of the second of t	23e. Did tot 1	23d. Date of de Month Dacco use contribute les 2 No 3 Pronto de de prior to de ath? 20 No 1 Ye	Day Year to the cause of death? Probably 4 Unknown uutopsy findings available completion of cause of s 2 No
of Vital Records, P.O. Box 6	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence) c.	uence of): ancy Il death 3 [leath 5 [l	Description of the control of the co	23e. Did tot 1	23d. Date of de Month Dacco use contribute les 2 🗷 No 3 🗆 Prior to death?	Day Year to the cause of death? Probably 4 Unknown uutopsy findings available completion of cause of s 2 No
of Vital Records, P.O. Box 6	ding Physician: The law requires that the death certificate be executed h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of pregnant at time of degree of Unknown contributing to death but not rest the special of the contribution of the con	uence of): uence of): ancy I death 3 [eath 5 [ulting in the u	Description of the control of the co	23e. Did tot 1	23d. Date of de Month Dacco use contribute le se 2 No 3 Properto de de prior to de ath? 22 No 1 Ye e)	Day Year to the cause of death? Probably 4 Unknown uutopsy findings available completion of cause of s 2 No
Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed cleath. cleath. ctor; After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	o Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of pregnance) 23c. If yes, outcome of pregnance of pre	uence of): ancy I death 3 [eath 5 [ulting in the u ER/Outpatier 28b. Time or Injury pme, farm, str	Description of the control of the co	23e. Did tot 1	23d. Date of de Month Dacco use contribute le se 2 No 3 Pror to death? 24b. Were a prior to death? 1 Ye e) Dacco 6 Nother (Spew injury occurred	Day Year to the cause of death? Probably 4 Dunknown uutopsy findings available completion of cause of s 2 No ASSISTED LIVING Bural Route Number,
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed cleath. cleath. ctor; After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of pregnance) 23c. If yes, outcome of pregnance of pre	uence of): ancy I death 3 [eath 5 [ulting in the u ER/Outpatier 28b. Time or Injury pme, farm, str	Distance Compared to the content of the content	23e. Did tot 1	23d. Date of de Month Dacco use contribute le se 2 No 3 Pror to death? 24b. Were a prior to death? 1 Ye e) Dacco 6 Nother (Spew injury occurred	Day Year to the cause of death? Probably 4 Dunknown uutopsy findings available completion of cause of s 2 No ASSISTED LIVING Bural Route Number,
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed cleath. cleath. ctor; After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Invo 9 Unknown Part II. Other significant conditions of the examiner? 1 Yes 2 Invo 9 Very 2 Invo 9 Very 2 Invo 9 Very 2 Invo 10 Very 2 Invo 11 Very 2 Invo 12 Accident Investigation of the examiner of Death Investigation of the examiner of the exa	Due to (or as a consequence of pregnant at time of degree of the state	uence of): uence	Dectopic pregnancy Other (specify) 26. Place of Dector at 3 DOA Other: 4 Nursing at Work? M 1 Yes 2 No reet, factory, office th occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date number	23e. Did tot 1	23d. Date of de Month Dacco use contribute le se 2 No 3 Prior to death? 24b. Were a prior to death? 270 No 1 Present and Number or Fin, State) Dause(s) and manner a late and place, and du lego. Date signed (Month)	Day Year to the cause of death? Probably 4 Unknown untopsy findings available completion of cause of s 2 No ASSISTED LIVING Bural Route Number, us stated, e to the cause(s)
of Vital Records, P.O. Box 6	Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death safe death. The law requires that the state of the s	Certification; To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of pregnant at time of degree of the state	uence of): uence	Dectopic pregnancy Other (specify) 26. Place of Dector at 3 DOA Other: 4 Nursing at Work? M 1 Yes 2 No reet, factory, office th occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date number	23e. Did tot 1	23d. Date of de Month Dacco use contribute le se 2 No 3 Prior to death? 24b. Were a prior to death? 270 No 1 Present and Number or Fin, State) Dause(s) and manner a late and place, and du lego. Date signed (Month)	Day Year to the cause of death? Probably 4 Unknown untopsy findings available completion of cause of s 2 No ASSISTED LIVING Bural Route Number, us stated, e to the cause(s)
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed cleath. cleath. ctor; After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of pregnant at time of degree of the state	uence of): uence	Dectopic pregnancy Other (specify) 26. Place of Dector at 3 DOA Other: 4 Nursing at Work? M 1 Yes 2 No reet, factory, office th occurred at the time, date and place vestigation, in my opinion, death occurred at the time, date number	23e. Did tot 1	23d. Date of de Month Dacco use contribute le se 2 No 3 Prior to death? 24b. Were a prior to death? 270 No 1 Present and Number or Fin, State) Dause(s) and manner a late and place, and du lego. Date signed (Month)	Day Year to the cause of death? Probably 4 Unknown untopsy findings available completion of cause of s 2 No ASSISTED LIVING Bural Route Number, us stated, e to the cause(s)
of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificate be executed cleath. cleath. ctor; After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of pregnant at time of degree of the state	uence of): uence	Description of the control of the co	23e. Did tot 1	23d. Date of de Month Dacco use contribute le se 2 No 3 Prior to death? 24b. Were a prior to death? 270 No 1 Preserved Date of death? 24b. Were a prior to death? 1 Ye 24b. Were a prior to death? 1 Ye 24b. Were a prior to death? 25c. No 3 Preserved 25c. No 3 Preserved 26c. No 3 Preserved	Day Year to the cause of death? Probably 4 Unknown untopsy findings available completion of cause of s 2 No ASSISTED LIVING Bural Route Number, us stated, e to the cause(s)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) APR'IL 2, Da 2006 **Physician** WEXLER 10:10 A M FLORENCE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE N/A 2606 TANEY ROAD 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | DEC . 20, 1918 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 ☑ F MD 214-14-3121 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ? is marked other then "natural", or iteme 23a or 28a-1 ehow traumatic event, the Madical Examiner must be notified at 1 Yes 2 □ No Director BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 2606 TANEY ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 💢 No Specify: à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, importent: if item 27 is marked other then eny injury or other traumetre. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GINSBERG DUBIN SOPHIE ISRAEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) 315 BELLTOWN ROAD - OWINGS MILLS, MD 21117 IRA WEXLER / SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/04/2006 HAR SINAI CEMETERY OWINGS MILLS, MD 21. Signature of Ineral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician DNeumonia /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 1 Yes 2 No 3 Probably 4 Tunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 185 autopsy performed? this certificate 1 Yes 2 1 NO 1 ☐ Yes 2 ☐ No Division of Vital To the Funeret Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 sesidence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann J Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeret Dire 1 Cerifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Sequence | Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and atte of certifier 29c. License number 29d. Date, signed (Month, Day, Year) 2/06 751896 Name and address of person who completed cause of death (Item 23a) (Type, Print) 21208 35 560 . Registrar's Signature 31. Date filed (Mg State Registrar

			1 - For State Registrar	State of Maryla		artment of H			R	eg. No.) 6	0532	
	Physici	ian	Decedent's Name (First, Middle, Last,		0)	- 023.	1		Date of Deat Month	Day	Year	3. Time of Death	
	/Media	cal	4a. Fecility Name (If not institution, give	etroot and number)	W	50 P RO L 4b. City, Town, or			MARCH	3 (2006 ty of Death	1(:32 P M	
	Examir	ner	NONTH WEST	1:05 PITA	4	RANDA		-7)			MORE	
F	Funeral		5. Social Security Number 6. Se.	7. Age (In yr.	s. last birthday,	 	If Under a	24 Hrs. 8.	Date of Birth			ace (State or Foreign	
	Director		014-14-0904 /	M 2□F 8	6 Yrs.	Months Days	nours	M. M	AR. 29	,1920	Coun	MA MA	
	and	}	Usuel Residence of Decedent 10a. State 10b. County	10c. C	City, Town or L	ocation		-			10	0d. Inside City Limits	
	Maryl fetho	jo	MD BALTIMO	RF	OWI	NGS MILLS					1 ☐ Yes 2 No		
	r 286	rec	10e. Street and Number	, , , , ,		10f. Zip Code			1	0g. Citizen of	What Coun	try?	
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28e-f show adout. The Madical Examiner mine the notified at	Funeral Director	4730 ATRIUM COURT	#604			21	117				USA	
	ems .	iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl				Yes or No-		ace - America		
20	s atte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:			Spec		WHITE	
-000 -000	hour tural	ed b	15. Decedent's Edu	Year or Dates:	16a, Dece	dent's Usual Occupa	ation			16b. Kind of I	Business/Ind		
<u>.</u>	nin 72 n "na Nedis	plet	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	durina most	of working		TOD. TRING OF	D03110341110	3317	
7	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ACC	TNATNUC				EXXON	CORPO	RATION	
-	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)					•	rst, Middle, I	Maiden Suma	,		
<u>8</u>	2 should be and Mental le marked raumatic ev	မ	MORRIS			DROW		LIA				LLOCH	
Mar	s 1 and 2 should t Health and Men ttam 27 le marke other traumatic		19a. Informant's Name/Relationship (T) DIANE ROMM / DAU(•		ing Address (Street a							
a)	1 and 1 Health tam 27		20a. Method of Disposition		Place of Dispe	osition (Name of		Date		20c. Location			
	permit. Pages 1 an Depertment of Heal Importent: If Itam 2 eny injury or other once.		1 ☐ Burial 2 ☐ Cremation 3 X F 4 ☐ Donation 5 ☐ Other (Specify)		-	matory`or other plac EMORIAL Pi		1/02/2					
апп	oorter		21. Signature of Funeral Service Ligens			2. Name and Addres				SON & E			
ă	Deperment of the perment of the permet of		Jay alar A			8900 REIS	TERST						
	Physician /Medical Examiner		23a. Payl 1/ Enter the disease, or compi shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		TIVE	ter the mode of dyin						Approximate Interval Between Onset and Death	
П		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					· · · · · · · · · · · · · · · · · · ·			
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	auanaa af).								
00,	be ex icien burial	IIcal E		Due to (of as a corrse	squerice or).								
000	ticate physis the	olbe		I									
.O. DOX	w requires that the death certilicate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3[Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day			*	
Ţ.	s that ned b e deta		Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying cause give	en in Part I.		23e. Did tot	pacco use cor	ntribute to the	e cause of death?	
cords,	equire en sig ould b	Completed by	ISCHEMIC CA	RPIOMYUP	ATHY	•			1 □ Ye	es 2□No	3 🗌 Proba	ably 4 @tinknown	
ວ	law re as be 2 sho	plet							24a. Was a autops	n 24b	. Were autop	osy findings available opletion of cause of	
	The tate h page	Son							perform	med?	death?	2 No	
lia.	Physicien: The lav this certilicate has al director, page 2	Be	25. Was case referred to medical examiner?					of Death (C/	heck only on	e)			
5	Physi this aldir	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	lospital: 1 Inpatient 2 (☐ ER/Outpatie		4 🗆 140			ence 6 🗆 Ot)	
5	ding After funer	to	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	k? Yes 2 ∐f		Describe III	ow injury occu	IITeu		
1818	or Atten tter deal birector; in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st			28f.	Location (St City or Town	reet and Num n, State)	ber or Rural	Route Number,	
	To the Hospital or Attending Physicien: The law requires that the within 24 hours attendeath. To the Funstel Director: After this certificate has been signed by th completely filled in by the funeral director, page 2 should be detached.	edical Ce	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deal	th occurred at the time	ne, date and pinion, deat	d place, and th occurred a	due to the ca	ause(s) and mate and place	nanner as sta	ated. the cause(s)	
	o the	Med	29b. Signature and title of certifier	and manifol stated.		29c. License	e number		2	9d. Date sign	ed (Month, L	Day, Year)	
	->-0			C 1	10	DS	777	22		MARC	# 7	2006	
	0		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type	Print)							
	<u> </u>		CEONARD RICHAR 31. Date filed (Month, Day, Year)	PSON 5401 C	THO COV	RT ROAD	RAN	PAUSTO	INN N	10 21	133		
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	CALL							

				1 - For State Registrar	State of M	larylar	•	artmen <i>rtificat</i>			d Men		ene	16	0533
		Physici		Decedent's Name (First, Middle, Last) Helen Elena Walke	er						2. C	Date of Death Month pril 3	Day 2006	Year	3. Time of Death 3:15 A M
		/Medio Examir		4a. Facility Name (If not institution, give s	treet and number,)			Town, or	Location of De		PIZZ	4c. Count	y of Death	
		Funeral Director		087-16-7230		ge (In yrs. 87	last birthday) Yrs.		1 Year	If Under 24 H	lin.	Date of Birth Month, Day, rch 13,	Year)		lace (State or Foreign
		Maryland f ehow	io	Usual Residence of Decedent 10a. State 10b. County DC			ty, Town or Lo							1	0d. Inside City Limits 1 X Yes 2 No
		with the	Director	10e. Street and Number 3001 Veazey Terra	ce. NW			10f. Zip	Code 2000	8			Og. Citizen of		-
	936	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28a-1 ehow I.a Medical Examinar must be indiffed at	by Funeral		12. Was Decedent Armed Forces 1 Yes 2 If If Yes, Give Year or Dates:	? [No			dent of H	spanic Origin? n, Mexican, Pu Specify:	(Specify lerto Rical		14. Ra	ce - Americ ack, White,	an Indian, etc.
	21215-0	l within 72 hor iene. r than "nature the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		5+)	(Give	dent's Usua kind of wo DO NOT us	rk done d se retired	luring most of	working	1	Socia	Business/In	
	yland 2	12 should be filed v h and Mental Hygis 7 le marked other traumatic event, III	To Be C	17. Father's Name (First, Middle, Last) Saverio Bizzarro							omin	a Mosc	atiel	Lo	
3-06	Baltimore, Maryland 21215-0036	Healt Healt tem 2		19a. Informant's Name/Relationship (Type Joseph F. Tangredi 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	/Nephew	•	1	Coquinosition (Narimatory or o	ina ne of other place			te Bea	ch, FI	2 337 City or To	706
4-	Baltir	permit. Pages Department of Important: If I any Injury or once.		21. Signature of Funeral Service License Mulliam A. Hu	mshues.	M01	Ro	2. Name an	d Addres		unera]	l Home,	Bethese	da-Chev	y Chase, Inc
C)315AM	8760,	Sate be executed whysician and hysician and hysician and the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complishook, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Equentially list emolitions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Chroni Due to (or as	c Ob s a consec ng Ci s a consec	struct: quence of): garett(quence of):	ive P		g, such as card			st,		Approximate Interval Between Onset and Death
6	O. Box 6	that the death certific ed by the ettending p detached for use as	nysiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fet	al death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>						ate of delive	ery Day Year
, Walke	Vital Records, P	The law requires ate hes been sign bage 2 should be	Completed by Physician/Me	Part II. Other significant conditions con History of Lung		but not res	sulting in the u	inderlying c	ause give	n in Part I.	_		s 2 No	3 🗆 Prob	ne cause of death? hably 4 □Unknown psy findings available impletion of cause of 2□ No
0)	Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:				Oth	26. Place of I					
Lefe	ō	Attending Physician: r death. sctor: After this certifics by the funeral director, I	atlon: To	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inj (Month, Da		ER/Outpatier 28b. Time o Injury		28c. Injury World	4 🗆 14013111		5 Resider			γ)
	Division	oital or Attendurs efter deathurs efter deathurs Infector:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e						(City or Town	State)		I Route Number,
		• Hospital	Medical	29a. Certifier 1. ☐ Certifying Phys (Check only 2. ☐ Medical Examin one)	ician: To the best er: On the basis of and manner s	of examina	owledge, deat ation and/or in	h occurred vestigation	at the tin , in my of	e, date and pl sinion, death o	ace, and c ccurred at	due to the ca t the time, da	use(s) and m te and place	anner as s , and due to	tated. the cause(s)
		To the within 2 To the complet	Me	29b. Signature and title of certifier				290	c. License	number		29	d. Date sign		
		25		30. Name and address of person who co				Print)	D006				-	1 3, 2	2006
		Sta	10	Steven Wilks, M.D. 31. Date filed (Month, Day, Year)	8600 C			own R	oad,	Bethes	sda,	MD 20	0814		
		Registi		APR 0.5.20	<i>(2)</i>		16 1	naste	,						

ORIGINAL

		•	1 - For State Registrar	State of Ma	aryland		artmer rtificat			and M	ental Hy	giene Reg. No.	UUD	10534
			1. Decedent's Name (First, Middle, L	ast)							2. Date of D Month	eath Day	/ Year	3. Time of Death
	Physici /Medic		Sarah Ande	erson							March	,	2006	8:00P M
	Examin		4a. Facility Name (If not institution, ga	ve street and number)			4b. City,	Town, or	Location of	of Death		4c.	County of Deat	
F	uneral			on Health Sex 7. Ag 1□M 2QF	& Re	st birthday)	If Unde	r 1 Year	t Wa	shir 24 Hrs. Min.	B. Date of Bi	rth	9. Birt	Georges hplace (State or Foreign untry)
D	irector		216-16-4883	10 M 28	8	2 Yrs.							,1923	Md.
pur	3		Usuel Residence of Decedent 10a, State 10b, County		10c. City.	Town or Lo	cation							10d. Inside City Limits
lanyla	8	5												1 XYes 2 No
he N	28a-f	ect	Md. PG 10e. Street and Number		LO.	rt Wa	1SN 1		n			10a Citi	izen of What Co	unta/2
with	10 20	늅		D					4					
eath	16 23	eral	3401 Tinkers	Branch W		13.1		2074		gin? (Spe	cify Yes or N		ted St	
ter d	호를	Š	1 Never Married 2 Married	Armed Forces?		. 10.1	If Yes, spe	cify Cuba	n, Mexican	n, Puerto I	Rican, etc.)		Black, White	
Irs af	5 5	by Funeral Director	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 ∏ №	Specify:				Specify:	ack
U Z I Z I 3-0030 filed within 72 hours after death with the Maryland	a a		15. Decedent's I			16a. Deced	dent's Usu	al Occupa	ation			16b. Ki	ind of Business/	
1 2	- T	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5	5+)	(Give	kind of wo DO NOT L	ork done d ise retired	luring mos)	t of workir	ng			
dwith	i i	mo:	Lienantary/occordary (0.12)	4	3+7	Resi	deni	t Ma	nage	r		Pr	ivate	
3	ent,	0	17. Father's Name (First, Middle, Las	t)							(First, Middle	e, Maiden	Surname)	
should be	ic e d	To B	John Holley						Lill	ian	Whit	ce		
should be	ir resum and weiter hygens ir resumed them 23s or 28s-f show them 21 is marked other than "naturel", or item 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	Γ.	19a. Informant's Name/Relationship	(Type, Print)								er, City o	r Town, State, 2	Zip Code)
and 2	27 is		Ernest Gough/s	son		3401 FORT ice of Disponetery, crer	Tir	ker	s Br	angl	. W28-	7.1.1		
s 1 a	Department of Hear Important: if Item 2 any injury or other 2000s.		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Na	me of	a)	Ď	ate		ocation - City or	Town, State
Pages	nt: if ry or		t ⊠Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		(,			Tai	ndover	FM.
mit. Pages	orta inju		21. Signature of Funeral Service Lice		114.	22	2. Name a	nd Addres	s of Facilit	y Hod	ines 8	E E	wards	F H
permit.	3 5 5 8		(Jamica)	Edwar	An									Ma.20746
			23a. Pa 1) Enter the disease, or conshert, or heart failure. List only Immediate Cause (Final	mplications that caused y one cause on each li	d the death.								Ittand	Approximate Interval Between Onset and Death
\N	ysician Medical aminer	<u>.</u>	disease or condition resulting in death) Sequentially list conditions,	a. Arterio Due to (or as	a conseque	ence of):	Perip	hera	1 Vas	scula	r Dise	ase_		
ate be executed	ohysician and the burial-transit	ai Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as										
cate	phys the	dicai		d										
The law requires that the death certific	been signed by the attending p should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 € No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal o	death 3	DEctopic p □ Other (s						23d. Date of del Month	ivery Day Year
hatt	ad by detac	<u>a</u>	Part II. Other significant conditions	contributing to death b	out not result	ting in the u	nderlying	cause dive	en in Part I		23e. Did	tobacco i	use contribute to	the cause of death?
ires j	sign B D	d b		ū		•	, ,				10	Yes 2	Mo 3□Pr	obably 4 Unknown
raguir D	need shoul	ete									04-146		0.05 144	to the second second second
The lav	cete hes page 2:	Completed		,								opsy formed?	death?	itopsy findings available completion of cause of 2 x No
V I C	ector	Be	25. Was case referred to medical examiner?	Hospital:	_		-	Othe	25		(Check only			
Physician:	this o	2	1 ☐ Yes 2 ☑ No	1 Inpatie		R/Outpatier			# CXIAN				6 Other (Spe	city)
ding .	After	<u></u>	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury		28c. Injury Work			28d. Describe	now injui	ry occurred	
To the Hospital or Attending	within 24 bounds after death. To the Funerel Director. After this certificate hes completely filled in by the funeral director, page 2.	ertification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Inj	jury - At hon tc. (Specify)	ne, farm, sti	M reet, factor		Yes 2 🗆			(Street and		ural Route Number,
he Hospits	in 24 hours the Funere pletely fille	edical C		Physician: To the best aminer: On the basis o	of examination		vestigation	n, in my of	pinion, dea			, date and	d place, and due	to the cause(s)
10	To t	Σ	29b. Signature and title of certifier	[]				c. License		,			te signed (Mont	
			1 Jellin	1 lan	2,			D3	520	06		MA	TREH 10	, 2006
2(10)		30. Name and address of person who William T. The		death (Item :	23a) (Type, LiUi	Print) NGST	and R	20	FOR-	TWASI	HINGT	on, no.	, 2006 20744
	Sta		31. Date filed (Month, Day, Year) MAD 2. 2. 20		rar's Signatu	ire /	ill s					_	7	

			1 - For State Registrar Amend#26. Per F		_	artment of Hea			ene	06	10535	
1	f	ş	Decedent's Name (First, Middle, Las					2. Date of Death	1		3. Time of Death	
	Physic /Medi		Henry A11	en, Jr.				Month March	13	2006	11:44A M	
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or Loca	ation of Death	4c. County of Death				
			7804 Suiter	Way		Lar	ndover		Prince George's			
tay.	Funeral		Social Security Number 6. Se	7. Ag XM 2 ☐ F	e (In yrs. last birthday)		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign	
	Director		579-74-0459 Usual Residence of Decedent		50 Yrs.			Mar. 17,		Was	h., DC	
	land		10a. State 10b. County		10c. City, Town or Lo	ocation				1	0d. Inside City Limits	
	Mary	to	Maryland Prince	George's		Lando	over				1X Yes 2 ☐ No	
	r 28e	Director	10e. Street and Number		1	10f. Zip Code		10	g. Citizen of	What Coun	itry?	
	h with	a D	7804 Suiter Way				20785		Uni	ted St	ates	
	ems Fran	Funerai	11. Marital Status	12. Was Decedent I	Ever in U.S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Spe	city Yes or No-	14. Ra	ace - Americ	an Indian,	
98	or its	y Fu	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 📉 N	No	_	pecify:	riioari, etc.,	Spec	ack, White, Af		
21215-0036	within 72 hours efter death with the Maryland ane. than "natural", or Items 23a or 28e-f show the Neutical Examinan nual be notified at	d by	3 Widowed 4 Divorced	Year or Dates:						Am	erican	
5	n 72	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occupation kind of work done during DO NOT use retired)	g most of workii	ng 1	6b. Kind of I	Business/Inc	dustry	
12	with Bne.	шо	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Bus Driv	70°		т	Privat	Δ.	
	filed Hygir other	Be C	17. Father's Name (First, Middle, Last)					(First, Middle, M				
lan	should be f and Mental H marked of umatic even	To B	Henry A	llen, Sr.				01a :	Mae By	rd		
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, the Man	-	19a. Informant's Name/Relationship (T	ype, Print)	19b. Mailir	ng Address (Street and N	Number or Rura	Route Number,	City or Town	n, State, Zip	Code)	
	and 2 laith a 27 is		Loretta Allen-Simm	nons/Siste	er 7	804 Suiter	Way, La	ndover,	MD 20	785		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28e-f show any injury or other traumatic event, the Neutical Examinational Description of Other traumatic event, the Neutical Examination of Other traumatic event, the Neutical Examination of Other traumatic event, the Neutical Examination of Other Proceedings.	1	20a. Method of Disposition 1 Burial 2 Cremation 3 D	Zamawal from Chair		sition (Name of matory or other place)				- City or To	wn, State	
Ĕ	Pag nent ant: h	١.,	4 Donation 5 Other (Specify)		l .	tion Cemete	ry 3/21	/2006	C1	inton	MD	
at	Departi Departi Importi any inji		21. Signature of Furreral Service Licens	See ()	22	. Name and Address of I	Facility S	tewart F	unera.	l Home		
_	70 E 9 9		John To	Dewar	X,UL	4001 Be	enning l	Rd., N.E	. Wash	n., DC	20019	
	Physician /Medical Examiner		23a. Part. Entler the disease, or comp shock, or hipart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each linaMetas	tatic Colo		ch as cardiac oi	r respiratory arres			Approximate Interval Between Onset and Death	
0,	sete be executed only sician and the burial-transit	Examiner	Sequentially list conditions, any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):							
8760,	te be ysicia ie bur	dicai		d								
9	tificel ig phy as th	ledi										
O. Box	The law requires that the death certificele be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the state of the sta	2 Fetal death 3	Ectopic pregnancy Other (specify)			1	ate of deliver	ry Day Year	
9	es that igned b	by P	Part II. Other significant conditions co	ntributing to death bu	at not resulting in the ur	nderlying cause given in F	Part I.	23e. Did toba	cco use con	tribute to the	e cause of death?	
Vital Records,	quire en sig uld b	ed b	Hypertensic	n				1 🗆 Yes	2 🗆 No	3 🗌 Proba	ably 4 Unknown	
ပ္သ	law requas been 2 should	Completed						24a. Was an	24b.	Were autop	sy findings available	
æ	The I	Eo						autopsy	pd2	prior to com death?	pletion of cause of	
ital		O	25. Was case referred to medical			26. 1	Place of Death	(Check only one)	3 No	1 🗆 Yes	2 □ No	
†	Physician: this certific	To B	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatien	t 3 DOA Cther: 4[☐ Nursing Hom	ne 5 ⊠ Residen	ce 6 Xon	ner (Spicarit	er's Home	
n of			27. Manner of Death 14 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury at Work?		8d. Describe how				
Division	en eat be he	Certification	2 Accident investigation			M 1 Yes	2 🗆 No					
Ξ	or Att after de Direct	Ħ.	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, farm, stre . (Specify)	eet, factory, office	2	8f. Location (Stre City or Town,		ber or Rural	Route Number,	
	spital cours af								ŕ			
	호 뉴 글 등	edical	29a. Certifier 1 A Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis of	examination and/or inv	occurred at the time, da restigation, in my opinion	ite and place, a i, death occurre	nd due to the cau d at the time, date	se(s) and m a and place.	anner as sta and due to	ited. the cause(s)	
	thic the	Med	29b. Signature and title of certifier	and manner sta	tea.	29c. License num						
	To Tool		1-tage : (.//	Kecc- X	A			290		ed (Month, C		
^	(m)		20 None	11771	requerer	D280	079		Marc	ch 16,	2006	
R	(4)		30. Name and address of person who co					π_1.		3.00	20705	
144	Sta	te	Francine A. H 31. Date filed (Month, Day, Year)	#2. Registra		rivoo peirs/	ATTIE D	r., bert	SVIII	, MD	20705	
	Registr		MAD 9 1 2006	Kea A	to do							

Registrar

State

31. Date filed (Month, Day, Year)

MAR 2 1 2006

111 Penn Street Baltimore, Maryland 21201

ted cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible					
Flease Type of Fifth in plack indelible link. Ensure All Copies Are Legiple	Places Type	or Drint in	Plack Indelible Ink	Engues All Conice	Ave I sollele
	riease Type	Of Print in	Diack indendie ink.	Elisure All Copies	Are Legible

	_	State of Maryland / Department of Health and Certificate of Death	Mental Hygi	9	10537
Physician		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	n Day Year	3. Time of Death
/Medical	J -	Charles Randolph Albert	March	19 2006	
Examiner	r	4a. Facility Name (If not institution, give street and number) 60 Augusta Drive 4b. City, Town, or Location of Death	h	4c. County of Dea	ıth
Funeral		60 Augusta Drive Elkton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Cecil 9. Bi	thplace (State or Foreign
Director		213-40-1183 IMM 2 F 63 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, DEC 22,	1942 M	thplace (State or Foreign ountry) aryland
p ,		Usual Residence of Decedent	1220 22,		
arylau show	_				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
sifer death with the Ma after death with the Ma off set regards to reast be multilised.	2	Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code		2- 02	
with Liber	5			g. Citizen of What C	
death ms 23	<u> </u>	60 Augusta Drive 21921 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1064— 13. Was Decedent of Hispanic Origin? (S	ipecify Yes or No-	United 14. Race - Am	
after or Ite	3	1 Never Married 2 Married 1 NYes 2 No 1904	to Rican, etc.)	Black, Whi	te, etc.
DO3(2	3 ☐ Widowed 4 ☐ Divorced If \$\forall 20 \text{No. Specify:} \\ \text{Year or Dates:} 1 ☐ Yes 2 \$\text{Yes No. Specify:} \\ \text{Yes of Specify:} \text{Yes or Dates:} \text{Yes of Specify:} \text{Yes of Specify:} \qq \qq		Specify: B	lack
21215-0036 ed within 72 hours after death with the Maryland Vgiena. her than "natural", or liems 23a or 28a-1 show it. If a Medical Exercipating a regal by notified an Completed by Funeral Director	ב ב	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired)	rking 1	6b. Kind of Business	/Industry
withii than than		Secondary (0-12) College (1-4or 5+) 9 College (1-4or 5+) Truck Driver		Transpor	tation
be filed tal Hyg d other event.			ne (First, Middle, M		Cation
aryland 21215-0036 should be filed within 72 hours after dea nd Mental Hygiena. I marked other than "natural; or items umail: event, tha Mudical Exercipating To Re Completed by Funer	2	James Randolph Albert Annie	Wright		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: If Item 27 is merked other than "natural; or Items 23s or 28s-1 show any injury or other traumatic event. The Medical Exercities at most be multiled at once. To Re Completed by Funeral Director		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
e, N 1 and 1 ealth em 27 ther tr	<u> </u>	Betty L. Moore/Sister 133 Brantwood Drive, 20a. Mathod of Disposition (Name of Disposition (
ages or of		1 Å Burial 2 □ Cremation 3 □ Removal from State Defaware Verenation of the place) Marc	h 23,	Oc. Location - City of	
Baltimore, sermit. Pages 1 a Department of Hee mportant: If Item any injury or othe	1			Bear, Del	
Balt permit. Departi Importi any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Fun 103 W. Stockton St	erals, P.	A.	land 21021
	1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Pnysician	1	Immediate Cause (Final			Onset and Death
/Medical		disease or condition resulting in death) a			
Examiner	.	Sequentially list conditions, b. Hypertex			
o, or and and rial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events c.			
al-transit	3	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
The law requires that the death certificate be executed attention between signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	3	a Cenomopalty			
fillicat rillicat as the					
Box 66 eath certific attending pl for use as t	3	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of de	
P.O. Box 68 nat the death certificated by the attending presented for use as the Physician/Med		1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.O. that the de sed by the sed b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute t	the cause of death?
Records, F he law requires tha e has been signed age 2 should be det	2		1 🗆 Yes	2 2 N o 3 □ P	robably 4 Unknown
al Record The law requir cate has been si page 2 should			24a. Was an	24b. Were a	utopsy findings available
The lav	5		autopsy perform 1 Yes 2	prior to	completion of cause of
Vital F sicien: Th certificate lirector, pag)	25. Was case referred to medical examiner?	th (Check only one		
Of V Physic r this ce ral dire	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	ome 5 X Resider	nce 6 Other (Spe	cify)
Vision of Vital Attending Physician: r death after this certification: the funeral director. If cation: To Be C		27. Magner of Death 1 Matural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	28d. Describe how	v injury occurred	
Division or Attending after death. Diractor: Afte din by the fune		2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determined	28f Location (Stre	eet and Number or R	ural Route Number
Division of tall or Attending P after death. The dip by the funeration: Certification:		4 Homicide determined building, etc. (Specify)	City or Town,	State)	arar noute Number,
spita hours ineral y filled		29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place	, and due to the cau	use(s) and manner a	s stated.
Divisit To the Hospital or Attendation within 24 hours after death to the Funeral Director: completely filled in by the Medical Certifical		(Check only 2 Mr. Tical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	rred at the time, dat	te and place, and du	to the cause(s)
To t com		29b. Signature and title of certifier 29c. License number	29	d. Date signed (Moni	
		m. ceerin mo 104823		3/21/0	6
2+IVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	F11-1	MAT -	
State		Tri-Chih Hsu, MD 223 W. Main St., 31. Date filed (Month, Pay, Year) MAR 2 2 2006 32. Redistrar's Signature	Elkton	MD 2	1921
Registrar		31. Date filed (Month, Pay, Year) MAR 2 2 2006 32. Redistrar's Signature 4			

			1 - For State Registrar	State of Maryland		artment o			nd Mental	Hygie Reg.	2111	6	10538
	· · · · · · · · · · · · · · · · · · ·		Decedent's Name (First, Middle, Last)							of Death		Year	3. Time of Death
	Physici /Media		Richard S. B	anks, Sr.					Marc	h 19	, 2006	1021	7:35 a M
	Examir		4a. Facility Name (If not institution, give s			4b. City, To			Death		4c. County		
			Gladys Spellman N		- 1 - 1 - 1 - 1 - 1	Chev		Under 24	Hre I a B	- C Pilate	Princ		eorges
	Funeral Director		5. Social Security Number 6. Sex 1K	7. Age (In yrs. Ia	Yrs.				Min. 8. Date Min. (Mon Sept	th Day Ye	1924	COU	place (State or Foreign ntry)
19	2		Usual Residence of Decedent		T								
	ehow	5	Maryland Prince G		Town or Lo Bowie	cation							10d. Inside City Limits 1X Yes 2 □ No
	28a-f	Director	10e. Street and Number			10f. Zip Ce	ode			10a.	Citizen of W	/hat Cou	ntrv?
	3a or		16010 Excalibur R	d. #A105			716			-	United		•
	death me 2	Funeral		12. Was Decedent Ever in U.S	13.	Was Deceden	nt of Hispa	anic Origin	n? (Specify Yes	or No-			can Indian,
36	s within 72 hours after death with the Maryland liene. I than "natural", or itame 23a or 28a-f ehow I'na Myzikou Examirar must be mullified at	by Fur	1 Never Married 2 Married	Armed Forces? 1-☑Yes 2 ☐ No If Yes, Give		т теѕ, ѕреспу 1 ∐ Yeѕ 2 <u>1</u> 2			Puèrto Rican, el	(C.)		k, White, $B1$	
00	hour tural	ed b	3 Widowed 4 Divorced	Year or Dates:	16a Dece	dent's Usual (Occupatio	n .		161	. Kind of Bu	siness/Ir	dustry
15	in 72 n nat	plet	(Specify only highest grade	completed)	(Give	kind of work of NOT use	done duri retired)	ng most o	of working	102	J. 14.11.0 01 D0		dostry
212		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Airc	raft S	ervi	cema	n		Privat	e	
pu	0 = >	Be (17. Father's Name (First, Middle, Last)						s Name (First, A			B)	
yla	should be and Mental marked c	P	James Marion Bank						Teresa				
Maryland 21215-0036	ss 1 and 2 should b of Health and Ments (Item 27 ie marked r other traumatic e	. 9	19a. Informant's Name/Relationship (Ty) Richard S. Banks,						or Aural Aoute		ity or Town, 3 7737		Code)
	s 1 and 2 of Health a ltem 27 is other trai		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name	of		Date	-	. Location -	City or T	own, State
MO	Pages ment of H ant: If Its ury or of	1	1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		natory or othe Memori		3	/24/200	6 S	uitlar	ıd, N	1d.
Baltimore,	permit. Page Department (Important; If any injury or once.		21. Signalur, of Funeral Service License			2. Name and	Address o	of Facility	pe Fune Pike/Fo		lomes,	P _M A.	20747
16t.	-		23a. Part1. Enter the disease, or compli	cations that caused the death.	Do not ent							114.	Approximate
	Physician		shock, or heart/failure. List only or Immediate Cause (Final	Chronic Ren	al Fa	ilure							Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	Due to (or as a consequent		11010							
ā	Examiner		Sequentially list conditions.	Arterial Sc		is							
	pe is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter or onlying Cause (Disease or injury	Due to (or as a consequent	ence of):								
_	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last	. Due to (or as a consequ	ence of):							-	
8760,	be ex												
687	ficate p phys	edic											
Box	eath certific attending p for use as I	Z	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnan		75 at a sia a sa					23d. Date	e of deliv	ery
	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burtal-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		∃Ectopic preg ∃Other (spec					Mor	ith	Day Year
P.0	that the de ad by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions cor		ting in the			o Dod I	220	Did tobac	an use contr	ibuto to I	he cause of death?
ds,	ires tha signed I be de	þ	Respiratorial Fa	_	_		•			1 ☐ Yes			bably 4 ∐Unknown
Sore	w requir been s	etec	Respiratorial Fa	rure, reriphe	Tal V	ascura,	r DI:	sease		Wasan			
Records,	The law ate has page 2 s	Completed								autopsy performed Yes 2	р	rior to co	opsy findings available impletion of cause of
a		မ C	25. Was case referred to medical			-,	24	e Place o	1 □		No 1	∐Yes	2 🗆 No
of Vital	Physician: this certific al director,	ToB	examiner?	lospital: 1 Inpatient 2 E	R/Outpatier	nt 3 DOA	Other:		ing Home 5		e 6 □Othe	t (Speci	(v)
			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c	. Injury at Work?				injury occurr		
Sion	Attending r death.	atic	1 ZNatural 5 Pending 2 Accident Investigation		,	М		2 □ No	0				
Division	를 를 들	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, sti	eet, factory, o	office			ition (Stree or Town, S		er or Run	al Route Number,
_	spital ours a serai filled		(Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinati									
	To the Hos within 24 h To the Fur completely	Medical	29b. Signature and tit	and manner stated.			icense n				Date signed		
	F 3 F 8		1 /2/1/1	Mil			00026				/20/20		
^	(1)		30. Name and address of per on who co	moleted cause of death (Item	23a) (Type		JUU2(7024			, 20, 20	,00	
K	0		Lester Miles, N				ndove	er, M	ld. 207	85			
	Sta		31. Date filed (Month, Day, Year)	Pegistrar's Signatu	uro -		-						
	Regist	rar	MAR 2 2 2006	Eline &	6,00								

DHMH 17 Rev 1/2001

Registrar

			For Stata Registrar	State of M	laryland / Dep <i>Ce</i>	artment of He			iene	6	105	+0
Ī	Physici	an	Decedent's Name (First, Middle Freda	M.		Bostic		2. Date of Deat	Day	Year	3. Time of	
	/Medic						i Dath	March	16 200		6:33	a ^M
	Examin	er	4a. Facility Name (If not institution		7	4b. City, Town, or L					1 1	
			725 Annapolis 5. Social Security Number		ge (In yrs. last birthday	Gambril If Under 1 Year	LS If Under 24 Hrs.	8. Date of Birth			indel piace (State o	r Foreian
	Funeral Director		232-50-5453	1 ☐ M 2 🗓 F	72 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) May 22	1933	Cour	virgi Virgi	
			Usual Residence of Decedent					, , , , , , , , , , , , , , , , , , ,				
	yland		10a. State 10b. County		10c. City, Town or L						IOd. Inside Cit	
	Mar e-f sl	Director	MD Anne	Arunde1	Gambri	lls					1 🗌 Yes	2 XN0
	th the	ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Cou	ntry?	
	15 wi		725 Annapolis	Road		210			USA			
	ems erms	Inel	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- Ameri k, White,	can Indian, etc.	
ဥ	s afte	by Funerai	1 Never Married 2 Marr	If Yes, Give] No		Specify:		Specify:	V	Vhite	
Š	within 72 hours after death with the Maryland one. then *neturel', or Items 23s or 28e-f show the Medical Examiner must be rediffed at		3 XXVidowed 4 ☐ Divorced	Year or Dates		edent's Usual Occupat	ion		16b, Kind of Bu	singss/ln	duetor	-
21215-0036	n 72	Completed	(Specify only highes	st grade completed)	(Giv	e kind of work done du DO NOT use retired)	iring most of work	ing	TOD. THIRD OF BU	31110337111	dosay	
7.	withi ene. then	mc.	Elementary/Secondary (0-12)	College (1-4or	5+)	memaker			Own	Home	2	
0	filed Hygi other		17. Father's Name (First, Middle,	Last)		1	18. Mother's Name	e (First, Middle, i	Maiden Surnam	в)		
Maryland	ld be ental ked o	To Be	John Floyd Car	r			Ruby	Burns				
3	shound M		19a. Informant's Name/Relations	hip (Type, Print)	19b. Mai	ing Address (Street ar	nd Number or Run	al Route Number	r, City or Town,	State, Zij	Code)	
Š	gos 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Items 23a or 28e-1 show or other traumatic event, the Marical Examinar must be notified at		Patty Asquith	(Daughter)	1210	Leonard D	rive, G1	en Burni	Le, MD 2	1060)	
Baltimore,	s 1 a of Hea item othe	32	20a. Method of Disposition		20b. Place of Disp	osition (Name of ematory or other place,		Date	20c. Location -	City or To	own, State	
Ë	Page ent c nt: If ry or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		0	e Nat. Cem		-2006	Baltimo	re,	MD	
=	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service	Licγns¶e	25- 21-52-50	22. Name and Address Hardesty	of Facility	Home I	2 Λ			
ñ	an pe		1-1/2 J.	An-		12 Ridge				D 21	401	
	-		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. Do not en	nter the mode of dying,	, such as cardiac	or respiratory arr	est,		Approximate Interval Bet	ween
	Physician	8	Immediate Cause (Final disease or condition		tage Laryn	eal cance	r				Onset and I	Death
	/Medical		resulting in death)	u	s a consequence of):	July Carret	•				<i>,,</i>	
	Examiner		Conventinily list conditions	b. Cereb	ral vascula	ar acciden	t				yr	
	D =	ner	Sequentially list conditions, in a course cause. Enter Underlying	Due to (or a	s a consequence of:							
	nd rans	Examiner	that initiated events	C	Fibrillat	ion					yrs	
Ď,	e exe ian a urial-		resulting in death) Last	`	s a consequence of):							
8/60,	icate be executed physician and s the buriat-transit	dicai		d. Hypot	hyroid						yrs	
0	eath certific attending p	Me	IF FEMALE:	23c. If yes, outcom	o of programmy							
ROX	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date Mor			Year
	the a	ysic	1 ☐ Yes 2 👿 No 9 ☐ Unknown	4□ Pregnant 9□ Unknown	at time of death 5	Other (specify)						
٦.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause giver	n in Part I.	23e. Did to	bacco use contr	ibute to t	he cause of d	leath?
g,	uires tha signed d be del	db	Hyperlipidem	-				1 □ Y	es 2□No	3 🗌 Proi	bably 4 💢	Jnknown
Vital Records,	w requir been si should I	Completed	C+	1				24a. Was a	24h V	Vara autr	opsy findings	available
ě	has ge 2 s	mpi	Gastroesopha	agear rellu	X			autops	sv p	rior to co	empletion of ca	ause of
<u></u>			Osteoporosis				(0	1 Tes	2 X No 1	Yes	2□ No	
7	ysicien: Is certific director,	Be	25. Was case referred to medica examiner?	Hospital:		Othor	26. Place of Deat			(0	. i	
	Physicien: r this certific ral director,	5 T:	1 ☐ Yes 2 👿 No 27. Manner of Death	1 ☐ Inpa 28a. Date of In	The state of the s	of 28c. Injury	at	me 5 Residence 128d. Describe he			<i>ly)</i>	
0	ding h. Afte fune	tion	1 Natural 5 Pendir 2 Accident investi		Day Year) Injury	Work	? es 2 □ No					
Division of	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of I	njury - At home, farm, s	treet, factory, office		28f. Location (S		er or Rur	al Route Num	ber,
2	after after Dire	Certification;	4 Homicide	building,	etc. (Specify)			City or Tow	n, State)			
	To the Hospitel or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	ledical C		ng Physician: To the besi	of examination and/or							;)
	o the ithin 2 o the o the o the omple	Med	29b. Signature and title of certifie	and manner	7 1	29c. License	number	2	29d. Date signed	(Month,	Day, Year)	
	F ¥ F 8		1/10/1	Roil	lini	D547	/ ₁ O		March 1	6 3	006	
			30. Name and address of person	who completed cause of	7	יודכם	+ 7		March l	.0, 2	.000	
			Allen Reilly		ast Rollin		ds, Balt	imore, M	nD 21228			
	Sta	ate	31. Date filed (Month, Day, Year)	2. Regis	strar's Signature	and a						
	Regist		MAR 21	2006	U SU AND							

State of Maryland / Department of Health and Mental Hygiene] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** a^{M} Nolan Vester Ball 2006 12:10 March 20, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 28 Queen Eleanor Elkton | Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ∏ M 2 ☐ F Director 221-16-1556 Yrs. 78 May 14,1927 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 la marked other than "natural", or Items 23a or 28a-f show other traumatic event, It e Modical Examinar must be notified at 10d. Inside City Limits Maryland Cecil E1kton 1 ☐ Yes 2XXNo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 28 Queen Eleanor 21921 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 X Yes 2 □ NoWar II If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene. Is marked other than "natural", or Itel Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No ģ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembly Line Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Teddy Ball Delpha Musick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an item 27 la Betty Ball/wife 28 Queen Eleanor, Elkton, Maryland 21921 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If iter 1XBurial 2 Cremation 3 Removal from State
' 4 Donation 5 Other (Specify)

1. Signature Fineral Science Holly Hill Memorial March 23, Baltimore, Maryland 2006 Gardens 22. Name and Address of Facility Crouch Funeral Home 21. Signature 127 South Main Street, North East, MD 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non-small cell Physician disease or condition resulting in death) livs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause, Unsease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed inding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has autopsy performed certificate 1 Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Magner of Death 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hours the Funeral Directory filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number March 22, 2006 a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA SOUS HOSPIC urka 31. Date filed (Month, Day, Year) 32. Registrar's Signatur 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18ay E1wood Vick Boteler March 2006ª 12:45P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Silver Spring Silver Spring Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 23, 1908 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 15 M 2□F 213-16-2346 97 Director Beltsville,MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. Count r 28a-f show 10d. Inside City Limits Prince George's Maryland Beltsville 1 Yes 2X No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai", or iteme 23a or Exerciser trass be 4903 Powder Mill Road 20705 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: δ White Specify: 3℃Widowed 4 □ Divorced Completed The Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Grocer retail sales it of Health and Mentel Hyg If Item 27 Is marked other or other traumatic event. 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mentel H tant: If item 27 Is marked otl 18. Mother's Name (First, Middle, Maiden Surname) Albert Francis Boteler Eliza Vick Morse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith J. Fafard -niece 11502 Blue Ridge Drive Beltsville, Maryland 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. Fort Lincoln Cemetery 3/24/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Ewardy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of): Examiner Dehydration Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examine physician and s the burial-transit certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by d be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Acute Renal Failure Completed 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? certificate Division of Vital 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4X Nursing Home 5 Residence 6 Other (Specify) this : After this funeral c 27. Manner of Death 1 2 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 5 Pending death. М 2 Accident investigation 1 ☐ Yes 2 ☐ No the Funeral Director: mpletely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Dire 4 Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) March 20, 2006 D53235 10 oleted cause of death (Item 23a) (Type, Print) 13635 Baltimore Avenue Laurel, Maryland 20707 31. Date filed (Month, Day, Year) MAR 2 2 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Mary	land / Dep		Health and	Mental Hyg	9	10543
1	141	-0	Decedent's Name (First, Middle, La.	st)				2. Date of Deat	h	3. Time of Death
	Physici /Media		Lucy Ann Bergm	ann				March 1	.9, 2006 Year	7:20 a M
ei ,	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town,	or Location of Deat	h	4c. County of Deat	h
1 1			406 Belton Road			Silver	Spring		Mon	tgomery
13.	Funeral Director	, X	5. Social Security Number 6. S 577-40-2533 Usual Residence of Decedent	ex 7. Age (In ☐ M 2☐ YF	yrs. last birthday, 75 Yrs.) If Under 1 Year Months Days			, 1930 Wash	hplace (State or Foreign untry) nington, DC
	and		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	f ehc	ō	Maryland Montgom	nery	Silver	Spring				1 ☐ Yes 2 ☐No
	28a-	ect	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What Co	
	with so or	<u>a</u>	406 Belton Road			2090	7	'	_	SA
	ne 23	era	11. Marital Status	12. Was Decedent Ever	in II S 13			necty Ves or No.	14. Race - Ame	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23s or 28s-f show many injury or other traumatic event, the Mudical Examinar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	If Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puerl Specify:	to Rican, etc.)	Black, White	
Ą	2 ho	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occu	ipation		16b. Kind of Business/	Industry
215	hin 7	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	ipation a during most of wo ad)	rking		,
7	d wit	E	Lionary/obsorioury (5 12)	2	Н	omemaker			Own Home	
פ	othe	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M	Maiden Surname)	
ā	lid by	To B	Robb French All	ensworth.			Viol	a Margare	et Flint	
Maryland	shound N		19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (Stree	t and Number or Ru	ıral Route Number,	City or Town, State, Z	(ip Code)
ž	is 1 and 2 of Health a item 27 le other trau		Carl K. Bergmann/	Hushand					, MD 20901	
ē,	Head Head	. 13	20a. Method of Disposition		Ob. Place of Dispo	osition (Name of	26		20c. Location - City or	
2	age into		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			matory or other pla even Cemete	100)		Silver Spri	ing, Marylan
Baltimore,	Trie arth	. (1	21. Signature of Funeral Service Licen							ing, Haryran
Ba	Dep tmpc		Banjui 2. S	Silis	50	00 Unive	rsity Blv	d, W, Sil		, MD 20901
李岭汉	Physician /Medical		23a. Part1. Enter the disease, or com, shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Coronary Due to (or as a cor	Artery		ing, such as cardiad	or respiratory arre	est,	Approximate Interval Between Onset and Death 2000
	Examiner	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Inclusion Due to (o. as a con		yositis				2003
,092	ate be executed hysicien and the burial-transit	cal Examiner	that initiated events resulting in death) Last	c Due to (or as a cord.	nsequence of):					
	ificat g phy as th									21/02/08/
	thet the death certifical led by the attending phy detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 □Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnance Other (specify)	ey		23d. Date of deli Month	very Day Year
۳.	d by detac	モ		entributing to double but an		-4-4		On Bidde		
Records,	law requires thet the as been signed by th 2 should be detache	ted by	Part II. Other significant conditions on Hypercholesterol	onthibuting to death but no	resulting in the u	nderlying cause gi	ven in Part I.	11	acco use contribute to s 2 ☐ No 3 ☐ Pro	the cause of death?
œ	The ste h	Completed						24a. Was ar autopsy perform 1 Yes 2	ned? death?	topsy findings available completion of cause of
Ë	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					th Check only one	9)	
=	Physician: this certifice ral director, p	2	1 162 5 3 140	Hospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA	hen: 4 🗌 Nursing H	ome 5 🔀 Reside	nce 6 Other (Spec	ufy)
_	ding P h. After t funera	ä	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	z8b. Time or	f 28c. Inju Wo	ry at ork?	28d. Describe ho	w injury occurred	
0	Attending it death. ector: After by the funer	atl	2 Accident investigation				Yes 2 □No			
	in Pite	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (Sp	ecity)			City or Town		
	24 h Fur stely	edical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	/sician: To the best of my iner: On the basis of exar and manner stated.	knowledge, death nination and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occur	, and due to the ca rred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	within 2 To the complet	M	29b. Signature and title of certifier			29c. Licen:	se number	29	d. Date signed (Month	, Day, Year)
	1		1 Hay 1 20	re mo		D2	22840	I.	March 21, 2	006
	1	- 1	30. Name and addr as of person who		(Item 22a) /T	Print\				
	Ì		Hazel Tape, M.D	. 1220 Plu	m Orchai		Silver	Spring, M	ID 20904	
	Sta Registra		31. Date filed (Month, Day, Year) MAR 2 2 2	32. Segistrar's S	ignatur					

0		Registrar 1. Decedent's Name (First, Middle,	Last)	- 00	ertificate of	Dodin		Date of Dea			3. Time of Death
Physic /Medi		The	1ma Everett	Brown				wonth arch	Day 27	Year 2006	1800 P ^M
Exami		4a. Facility Name (If not institution,			4b. City, Town, o					ity of Death	1 2000 2
		Union Hospital 5. Social Security Number		and the same to at high day	Elkton		A Lien on	(5)		ci1	
Funeral Director		222-16-6012	1 TM 257 E	ge (In yrs. last birthda 75 Yrs.	Months Days	Hours	Adin /	Date of Birth Month, Day OV 8,	1930	Coui	place (State or Foreigi htry) AWAYE
		Usual Residence of Decedent					11	· · · · ·	1730	DCI	awarc
any journe motivate a manage desired than fraction, of nems and be notified at posses. But instruction of the notified at posses.	7	10a. State 10b. County	-	10c. City, Town or						1	10d. Inside City Limits 11∏ Yes 2 ☐ No
notifi	rect	Maryland Ceci		E1ktor	n 10f. Zip Code		· · · · · · · · · · · · · · · · · · ·		10g. Citizen of	f What Cour	
2	I D	913 Bridge Str	eet.		21921					ed Sta	
	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13	3. Was Decedent of H	lispanic Orig	in? (Specify	Yes or No-	- 14. Ra	ace - Americack, White,	can Indian,
	by FL	1 ☐ Never Married 2 ☐ Marrie 3 🏋 Widowed 4 ☐ Divorced			1 ☐ Yes 2 🎇 No	Specify:		.,,	Spec	eify:	
	ted t	15. Decedent's	Education	16a. Dec	cedent's Usual Occup	ation			16b. Kind of		nite
	Be Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	(Giv	ve kind of work done DO NOT use retired	durina most (of working				
	Con	10			ookkeeper					ountir	ng
	Be	17. Father's Name (First, Middle, La Joseph Everett							Maiden Suma	ame)	
	2	19a. Informant's Name/Relationshi		19b Ma	iling Address (Street		el Mae			n State 7in	Code
:		Kenneth A. Bro			3 Bridge S						
	1	20a. Method of Disposition 1 X Burial 2 □ Cremation 3	Damoual from State	20b. Place of Disa	position (Name of		larch :		20c. Location		
	. 6	`4 □Donation 5 □ Other (Spe		Memoria	ematory or other place lanor l Park		2006	,	E1kto	n, Mar	ry1and
once.		21. Signature of Funeral Service Li	censee	H	22. Name and Addre	ss of Facility for F	unera	ls. P	. A .		
any injury or other	-	23a. Part1. Enter the disease, or c	ces) (lum	d the death. Do not e	Hicks Home 103 W. Sto	ckton	Stree	t, El	kton, N	Maryla	and 21921 Approximate
		shock or heart failure. List or									
-		Immediate Cause (Final	niy one cause on each i	ine.					1001,		Interval Between Onset and Death
ical			a. Heta	ine.	une ca						Interval Between
cal		Immediate Cause (Final disease or condition resulting in death)	a. Heta Due to (or as	static L a consequence of): NIC OBST	une ca	th CEV					Interval Between Onset and Death
al	nlner	Immediate Cause (Final disease or condition resulting in death)	a. Heta Due to (or as	static (a consequence of):	une ca	th CEV				1	Interval Between Onset and Death
al er	Examiner	Immediate Cause (Final disease or condition	a. Meta Due to (or as b. CHRO Due to (or as	static L a consequence of): NIC OBST	une ca	th CEV				1	Interval Between Onset and Death
eal ier	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated eyents	a. Meta Due to (or as b. CHRO Due to (or as	a consequence of): a consequence of):	une ca	th CEV				1	Interval Between Onset and Death
al er	Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, finally learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Meta Due to (or as b. Due to (or as c. Due to (or as d.	a consequence of): a consequence of):	une ca	th CEV					Interval Between Onset and Death
ıl	ian/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a. Due to (or as c. Due to (or as d. 23c. If yes, outcome	a consequence of): a consequence of): a consequence of):	LEctopic prognancy	hu CEA			A 5 £ 23d. D.	rate of deliver	Interval Between Onset and Death 8 worth 1
cal ner	nysician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	a. Due to (or as c. Due to (or as d. 23c. If yes, outcome	a consequence of): a consequence of): a consequence of):	LUG CA	hu CEA			A 5 £ 23d. D.	ate of delive	Interval Between Onset and Death 8 worth 1
er	Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as pue to (or as d. Due to (or as pue to (or as	a consequence of): a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5	Ectopic pregnancy	PULMO	MAW	DISEA	23d. D.	ate of deliver	Interval Between Onset and Death 8 worth 1
al er	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, farry, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as pue to (or as d. Due to (or as pue to (or as	a consequence of): a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5	Ectopic pregnancy	PULMO	MAW	D \ \$E ,	23d. D. M	ate of deliver	Interval Between Onset and Death Onset and Death 18 Months
al	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, farry, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as pue to (or as d. Due to (or as pue to (or as	a consequence of): a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5	Ectopic pregnancy	PULMO	YAW	23e. Did to	23d. D. Moobacco use cores 2 \(\subseteq No \)	ate of deliver	Interval Between Onset and Death Onset and Death 18 worths
er er	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, farry, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as pue to (or as d. Due to (or as pue to (or as	a consequence of): a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5	Ectopic pregnancy	PULMO	YAAW 2	23e. Did to	23d. D. M. M. Dibacco use cores 2 \(\text{No} \) No an 24b. sy	ate of deliverations and the state of deliverations and the state of deliverations are stated as the state of deliverations and the state of deliverations are stated as the state of deliverations are stated as the state of deliverations are stated as the stated are state	Interval Between Onset and Death Onset and Death 18 Months
al er	Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, farry, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as d. Due to (or as second	a consequence of): a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5 but not resulting in the	Ectopic pregnancy Other (specify) underlying cause give	PULMA PULMA en in Part I.	YAAW 2	23e. Did to	23d. D. Months of the second o	ate of deliver	ony Day Year Te cause of death? The cause of death? The cause of death? The cause of death?
al	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fi any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as d. Due to (or as second	a consequence of): a consequence of): a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5 but not resulting in the	Ectopic pregnancy Other (specify) underlying cause give	en in Part I. 26. Place o	MANY 2 1 of Death (Che	23e. Did to 1 PY 24a. Was a autopoperform Yes ack only or one of the control of t	23d. D. M.	ate of deliver forth all problems autoprior to cordeath?	ory Day Year ably 4 Unknown psy findings available moletion of cause of 2 No
al	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated swents resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence of): NC OBST a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5 out not resulting in the	Ectopic pregnancy Other (specify) underlying cause give	en in Part I. 26. Place o	of Death (Cho	23e. Did to 1 PY 24a. Was a autopoperform Yes ack only or one of the control of t	23d. D. M.	ate of deliver forth all problems autoprior to cordeath?	ory Day Year ably 4 Unknown psy findings available moletion of cause of 2 No
al	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fi any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence of): NC OBST a consequence of): a consequence of): of pregnancy 2 Fetal death 5 out not resulting in the put not resulting in the and 2 Fetal death 5 out not resulting in the and 2 Fetal death 5 out not resulting in the and 2 Fetal death 5 out not resulting in the and 2 Fetal death 5 out not resulting in the and 2 Fetal death 5	ent 3 DOA Other of 28c. Injun Work	en in Part I. 26. Place of the series of th	of Death (Cheing Home 28d. I	23e. Did to 1	23d. D. M.	ate of deliver flows to the state of the sta	ory Day Year ably 4 Unknown psy findings available moletion of cause of 2 No
al er	o Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fi any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence of): NC OBST a consequence of): a consequence of): of pregnancy 2 Fetal death 5 time of death 5 out not resulting in the ent 2 ER/Outpatie Injury ury - At home, farm, s c. (Specify)	ent 3 DOA Other of 28c. Injun Work	en in Part I. 26. Place of the Purchase of th	of Death (Cheing Home 28d. I.	23e. Did to 1 Yes 24a. Was a autops perform 15 Reside Describe he ocation (Sity or Town	23d. D. Month of the state of t	ate of deliverations of the state of deliveration of the state o	ery Day Year Day Year ably 4 Unknown psy findings available mpletion of cause of 2 ETNo
cal	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending investigal 3 Suicide 6 Could no determine (Check only 2 Medical Exercises Medical Exerci	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence of): NC OBST a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5 out not resulting in the ant 2 Fetal death 5 ury At home, farm, s c. (Specify) of my knowledge, deaf examination and/or if	ent 3 DOA Other (specify) of 28c. Injury Work M 1 Street, factory, office	en in Part I. 26. Place of the Nursey at the Cartes and the and the and the and the cartes are the cartes and the cartes are the cartes and the cartes are	of Death (Cheing Home 28d. I	23e. Did to 1 24a. Was a sutops perform 1 Yes 24c only on 5 I Reside Describe he 25c ocation (Si 25c) or Town	23d. D. Moobacco use cores 2 No an 24b. symmet? 2 No ow injury occupance 6 Oct ow injury occupance (s) and more and Nummar, State)	ate of deliver from the form of the form o	onset and Death Onset and Deat
	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Undertying Cause (Disease or injury that initiated events that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence of): NC OBST a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5 out not resulting in the ant 2 Fetal death 5 ury At home, farm, s c. (Specify) of my knowledge, deaf examination and/or if	ent 3 DOA Other (specify) of 28c. Injury Work M 1 Street, factory, office	PULNA PULNA PULNA 26. Place of the pulna 26. Place of the pulna 27. All Nurs 28. Place of the pulna 29. Place of the puln	of Death (Cheing Home 28d. I	23e. Did to 1 24a. Was a sutope perform 1 Yes 24c only one ocation (Singlety or Town 25 Describe however the cuthe time, d	23d. D. M.	ate of deliver don'th all problems autoprior to cordeath? I her (Specify and the specify and the specific a	Interval Between Onset and Death Onset and Death 18 worths The Cause of death?
cal ner	edical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence of): NC OBST a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5 out not resulting in the ant 2 Fetal death 5 ury At home, farm, s c. (Specify) of my knowledge, deaf examination and/or if	ent 3 DOA Other (specify) underlying cause given by the contract of the course at the time investigation, in my or 29c. License	PULNA PULNA PULNA 26. Place of the pulna 26. Place of the pulna 27. All Nurs 28. Place of the pulna 29. Place of the puln	of Death (Cheing Home 28d. I. C.	23e. Did to 1 Yes 24a. Was a autops perform 1 Yes 25 Residue 25 Residue 26 Are only on the cithe time, describe the time, describe the cithe time, described the cithe cithe cithe time, described the cithe cithe cithe cithe cithe cithe cithe cithe cit	23d. D. M. State) 23d. D. M. State) 23d. D. M. State) 24b. State and Nummer, State) 24b. State and Nummer, State) 24b. State and Nummer, State and Place, 29d. Date signed	ate of deliver from the form of the form o	interval Between Onset and Death Onset and Death 18 worths The Cause of death?
eal	edical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could no determine (Check only 2 Medical Examiner) 29a. Certifier (Check only 2 Medical Examiner) 29b. Signature and title of certifier	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence of): NC OBST a consequence of): of pregnancy 2 Fetal death 3 t time of death 5 out not resulting in the series of the series	ent 3 DOA Other (specify) underlying cause given by the course of the co	en in Part I. 26. Place of the property of th	of Death (Cheing Home 28d. I. C.	23e. Did to 1 Yes 24a. Was a autops perform 1 Yes 25 Residue 25 Residue 26 Are only on the cithe time, describe the time, describe the cithe time, described the cithe cithe cithe time, described the cithe cithe cithe cithe cithe cithe cithe cithe cit	23d. D. M.	ate of deliver from the form of the form o	interval Between Onset and Death Onset and Death 18 worths The Cause of death?
	edical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as b. Due to (or as c. Due to (or as d. Due	a consequence of): NC OBST a consequence of): a consequence of): of pregnancy 2 Fetal death 3 t time of death 5 out not resulting in the series of the	ent 3 DOA Other (specify) underlying cause given by the course of the co	en in Part I. 26. Place of the service of the serv	Death (Cheing Home 28d. I. C.	23a. Did to 1 24a. Was a autope perform yes ack only or 5 Describe horocation (Sitty or Town the time, d	23d. D. M. State) 23d. D. M. State) 23d. D. M. State) 24b. State and Nummer, State) 24b. State and Nummer, State) 24b. State and Nummer, State and Place, 29d. Date signed	ate of deliver forth all problems autoprior to condeath? I were autoprior to condeath? I yes Ther (Specify forth all problems as st., and due to be death and the forth all problems are as st., and due to be death and the forth all problems are as st., and due to be death and the forth all problems are as st., and due to be death and the forth all problems are as st., and due to be death and the forth all problems are as st.	interval Between Onset and Death Onset and Death 18 worths The Cause of death?
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit unit of a same and a same and a same and a same a same and a same a	Medical Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as b. Due to (or as d. Due	a consequence of): NC OBST a consequence of): of pregnancy 2 Fetal death 3 t time of death 5 out not resulting in the put not resulting in the separate of the separate o	ent 3 DOA Other (specify) underlying cause given by the course of the co	en in Part I. 26. Place of the property of th	Death (Cheing Home 28d. I. C.	23a. Did to 1 24a. Was a autope perform yes ack only or 5 Describe horocation (Sitty or Town the time, d	23d. D. M. Debacco use cornes 2 No ne 24b. Symmed? 2 No ne) ence 6 Ot ow injury occu treet and Num, State) sause(s) and mate and place, 29d. Date signer ARCL	ate of deliver forth all problems autoprior to condeath? I were autoprior to condeath? I yes Ther (Specify forth all problems as st., and due to be death and the forth all problems are as st., and due to be death and the forth all problems are as st., and due to be death and the forth all problems are as st., and due to be death and the forth all problems are as st., and due to be death and the forth all problems are as st.	Interval Between Onset and Death Onset and Death 18 worths If Early Day Year The cause of death?

		Amend Item 24a per State of Maryland / Department of Health and Certificate of Death	Mental Hyg	giene Reg. Nô.	10545
		1. Decedent's Name (First, Middle, Last)	2. Dete of Dea	ath	3. Time of Death
	Physician /Medical	Joann Lucretia Betts	March	21, 2006	09:50 PM
	Examiner	4a Fecility Name (If not institution, give street and number) 4b. City, Town, or	Location of Deeth		
		Julia Manor Health Care Center Hagerst	own	Washin	gton
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr Months Deys Hours Mir		y, Year) 9.	Birthplace (State or Foreign Country)
	Director	220-58-4716 57 Yrs.	May 09	,1948	MD
3	ž	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
	d d				TV Yes 2 □ No
1	or 28a-fa be nother	MD Washington Hagerstown 10e. Street end Number 10f. Zip Code		10g. Citizen of Wha	
	Sa d				
1	r tems 23s	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - A	American Indian,
Maryland 21215-0020	Deportment of Health and Mentel Highen. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinet must be notified at once. To Be Completed by Funeral Director		rto Rican, etc.)	Specific	white, etc. White
5-0	tel Hygiene. Id other than "nature avent, the Medical Be Completed	15. Decedent's Education 16a. Decedent's Usual Occupetion	4.4	16b. Kind of Busine	
7	900	(Specify only highest grade completed) Elementery/Secondary (0-12) College (1-A2r 5+) (Give kind of work done during most of work done during m	orking		
7	Contraction	12 1 Homemaker		Own Hom	e
בו בו	d oth	17. Fether's Name (First, Middle, Last) 18. Mother's Na	me (First, Middle,	Maiden Sumame)	
Z da	Men Men To	Melvin L. Betts Hele	n G. Pier		
Mai	ls m	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fig. 19b. Mailing Address)		ac Emais S	esterotamen (
٠ . و	Healt Pm 27 ther	Lynn Younker/Son 253 Merrimack Living F	alling Wa	iters,W	25419
altimore,	nent of I	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)		20c. Location - City	
ׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅׅ֟֝֞֝֟֝֞֝֟֝	rtmer	4 Donation 5 Other (Specify) 21. Signature Funeral Service-Licensee 22. Name and Address of Facility	03/25/06 E	Big Pool,	MD
Ba	Depe Impo	21. Signature of Funeral Service-Licensee 22. Name and Address of Facility	141 W	West Main	Street
		Grove Funeral Home	,P.A. Har	cock, MD	
*		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ic or respiratory arr	est,	Approximate Interval Between Onset and Death
	hysician /Medical	Immediate Cause (Final CO O CITAL HEALT FAILURE			Onder and Bedan
Ε	xaminer	Immediate Cause (Final disease or condition resulting in death) Long attract Heart Failure Due to (or as a consequence of): Renal Failure			1
	ةِ السواح	Report Fair Live			
\ \frac{1}{2}	in i	Sequentially list conditions Due to (or as a consequence of):			
Ö,	an er uriel-t	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Cause (Disease or injury Cause)			
58760, <	physician end is the bunel-transit edical Exeminer	Cause (Disease or injury that initieted expents resulting in death) Last Due to (or as a consequence of):	<u> </u>		
	ing p				
Box ath cert	d by the ettending leteched for use es	U .			1
၁ နို	the child is held in h	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	bacco use contrib	ute to the cause of death?
_ <u> </u>	been signed by the estould be deteched	Deizures	1 🗆 Y	es 2 No 3	Probably 40 Vinknown
ecords,	isigner Id be d d by	d	24a. Wes a	n autoney 24	b. Were autopsy findings
OS A	beer shou		perform		available prior to completion of cause
T He	certificate has been s lirector, page 2 should o Be Completed			or samue	of death?
	or, pa	25. Was case referred to medical 26. Place of De	T Ye		1 Yes 2 No
00	is certifice director, p	examiner?	ath (Check only on	ence 6 🗆 Other (S	(nacify)
	÷ • • • •	27. Manng- of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury at		ow injury occurred	респу
VISION	ath. r: After ne funer atlon:	1 ☑ Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
UIVISION or Attending	rs efter death. al Director: After t led in by the funere Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St.	reet and Number of	Rural Route Number,
	C C C				
e Hosp	within 24 hours efter death. To the Funeral Director: After completely filled in by the funer Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (□ Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place (□ Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place (□ Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place (□ Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place (□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time.			r as stated. due to the cause(s)
_ o⊤	within To th comp	29b. Signature and title of certifier 29c. License number	29	9d. Date signed (Me	onth, Day, Year)
		08062213		3/22/21	•
	6	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Provice Braum, MD 34B, Mill Spect, Hager Town	170 21	740	
	State Registrar	29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number	-		

DHMH 16 Rev 6/95

		1 - For State Registrar	State of Ma			of Health ar of Death	nd Mental Hy	giene Reg. No.	10546
/Me	sician edical miner	1. Decedent's Name (First, Middle Simon D. Beachy 4a. Facility Name (If not institution,			4b. City. Toy	vn, or Location of		20 2006 Year 4c. County of Death	3. Time of Death 3:15 PM _M
Funer	ral	1705 Foy Rd.		(In yrs. last birthday, 98 Yrs.	Accide	ent Gear If Under 24	Hrs. 8. Date of Birl	Garrett th Yearh 9. Birth	place (State or Foreign
Direct		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation		Dec. 19		sylvania 10d. Inside City Limits 1 □ Yes 2 🛣 No
h with the M 23e or 28a-1	Funeral Director	MD Garret 10e. Street and Number 1705 Foy Rd.		Accident	10f. Zip Co 21520			10g. Citizen of What Cou	
5-0036 72 hours after death with the Maryland inaturel; or Items 23e or 28e-f show diest Exporer must be notified a	by Funer	3 Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 M If Yes, Give Year or Dates:		If Yes, specify	of Hispanic Origin Cuban, Mexican, in No Specify:	n? (Specify Yes or No Puerto Rican, etc.)	Black, White,	
Maryland 21215-0036 to 2 should be filed within 72 hours aff tilt and Mental Hygiene. 27 Is marked other then "naturel", or rraumatic event, the Medical Exerci-	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)		(Give	DO NOT use re	one durina most c	of working	16b. Kind of Business/Ir Self-Employ	dustry
ryland; hould be filed Mental Hyg markad othe matic event,	To Be C	17. Father's Name (First, Middle, L	7	19h Mail	ing Address (St	Amanda	s Name (First, Middle, a Miller	Maiden Sumame) er, City or Town, State, Zi	a Coda)
Baltimore, Maryland 21215-0036 parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other then "naturelt, or Items 23e or 28a-1 show any injury or other traumatic event, it a Medical Examinat to notified at	once.	Lucy Maust / Dauge 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp. 21. Signature of Funeral Service L.	ghter 3 □Removal from State ecity)	20b. Place of Dispo cemetery, cre Maple Gle	Foy Rd. osition (Name of matory or other en Ceme	, Accide	ent, Md. 21 Date rch 26,200		own, State
Pnysicia /Medic Examin	an eal er	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	aua to to r as a	the death. Do not en	ter the mode of				Approximate Interval Between Onset and Death
Hecords, P.O. Box 68760, The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be datached for use as the burial-transit	Medicai Examiner	that initiated events resulting in death) Last	d	consequence of):			· -		
P,O. BOX 6 that the death certific ad by the attending p datached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Petal death 3	□Ectopic pregni □ Other (s <i>pecif</i>)			23d. Date of delive Month	ery Day Year
COTCLS, F w requires that been signad the should be dat	þ	Part II Other significant condition	s contributing to death but	t not resulting in the u	inderlying cause	e given in Part I.	23e. Did to	7 (pably 4 □Unknown
Vital Rec	e Completed	25. Was case referred to medical				26. Place o	24a. Was autop perfor 1 Yes	prior to co death? 2 No 1 Yes	psy findings available mpletion of cause of 2 No
DIVISION Of VITAI RECORDS, To the Hospitel or Attending Physicien: The law requirest within 24 hours after death. To the Funarel Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be or	Certification: To B	examiner? 1 Yes 2 No 27. Manner of leath Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	t be	Year) 28b. Time o	f 28c. I	Other: 4 Nursi	ng Home 5 Resid	dence 6 Other (Specificow injury occurred	
Hospite 4 hours Funarel ely filled	edicai Certif	4 Homicide determing 29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of xaminer: On the basis of a	my knowledge, deat	h occurred at th	e time, date and	City or Tow	cause(s) and manner as s	tated
To the within 24	Med	29b. Signature and title of certifier 30. Name and address of person w	and manner state	e // i	29c. Lic	pense number D 1 30 6		29d. Date signed (Month,	Day, Year)
87	State istrar	Dr. V. R. Felipa 31. Date filed (Month, Day, Year)	a, M.D., 925 32. Registra	Bishop-Wa	alsh Dr.		cland, MD	21502	

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 19, 2006 Year **Physician** David Olen Beachy 10:10 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3059 Hare Hollow Rd. Grantsville Garrett If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Jan. 27, 1943 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X**1M 2□ F 217-42-6378 63 Director Pennsylvania Usual Residence of Decedent death with the Maryland 10b County 10c. City, Town or Location 10a State ar than "natural", or Itams 23a or 28e-f show 10d. Inside City Limits Completed by Funeral Director MD Garrett 1 Tyes 2 No Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3059 Hare Hollow Rd. 21536 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural, or Ital ny or other traumatic event, its Mcclical Exam has ny or other traumatic event, its Mcclical Exam has Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Keystone Lime Co. Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellsworth Beachy Martha Marie Baum 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3059 Hare Hollow Rd., Grantsville, MD Marlene Beachy/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or `4 Donation 5 ☐ Other (Specify) Bittinger Cemetery March 24, 2006 Bittinger, MD 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COPD /Medical Due to (or as a consequence of): Examiner Asthma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medicai Examiner Due to (or as a consequence of): or Attanding Physician: The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐ Pregnant at time of death Month Day Year 5 Other (specify) P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? After ! 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funaral C 1 Critiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 0 aun 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Dr. Kenneth R. Buczynski, MD 311 North 4th Street, Oakland, MD 21550 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 3 2006 Registrar

CHARLES H. BORDLEY State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician 0410 Charles Henry Bordley 19, 2006 4c. County of Death MARCH /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner QUEEN ANNE"S Southbound 301 @ ROUTE 304 CENTREVILLE Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y) 12/23/ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X**] M 2□ F Yrs. 219-36-6585 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r then "naturel; or Iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Centreville MD Oueen Annes Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21617 1631 Burrisville Rd Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black ģ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Queen Annes County Parks Maintenance Pages 1 and 2 should be filed w thent of Heelth and Mental Hygier tant: If item 27 is marked other it jury or other traumatic event, the 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mattie Pearson Tinley Albert Bordley ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1631 Burrisville Rd Centreville, MD 21617 Gloria Baynard Bordley (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or Male & Female Lodge 3/25/06 Burrisville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bennie Smith FH-Dover, DE srince 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Due to (or as a consequence of): mores /Medical resulting in death) Examiner Sequentially list conditions, any, be my limmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown 23e. Oid tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Completed by of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 2 Yes 2 □ No Yes Yes 2□ No or Attending Physician: funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) AT SCENE 1 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month. Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Injury Division dower i motor vehi 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s efter death. 3:48 A M March 19,2006 culision with truch investigation the f 2 XAccident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined within 24 hours efter dea To the Funerel Directo completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 30 4 4 Homicide centente To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical (Check only one) 20 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier MARCH 19, 2006 O.C.M.E men 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE.MARYLAND 21201 Jasha Zareenberg 32. Registra Signature 31. Date filed (Month, Day, Year) State MAR 2 3 2006 >

Registrar

Beles

			1 - For State Registrar	State of Man		rtment of h			giene 6	10549
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Las Aa. Facility Name (If not institution, give	R	Brook		or Location of Death	2. Date of Dea	Day Year 4c. County of Dea	3. Time of Death 6 0510 M
	Funeral Director	400	5. Social Security Number 214 - 36 - 5786 Usual Residence of Decedent	TOSPITE (III)	n yrs. last birthday) 65 ^{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 9/20	(Year)	rthplace (State or Foreign ountry) MD
	the Maryland 28a-f ahow rotified at	Director	10a. State 10b. County MD KENT 10e. Street and Number		Oc. City, Town or Loc WORTON	cation			log. Citizen of What C	10d. Inside City Limits 1 Yes 2 No
9003	72 hours after death with the Maryland hetural; or Itams 23a or 28a-f ahow digal Examiliar innel be recitled at	by Funeral	13227 WYBLE RD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve- Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		21678	lispanic Origin? (Spe an, Mexican, Puerto I		USA 14. Race - Am Black, Whi Specify: BL.	erican Indian, te, etc.
Maryland 21215-0036	filed within Hygiene. other than	e Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5+)	(Give k	O NOT use retired	during most of working	ng	16b. Kind of Business CHRYSLER	
larylan		ToB	JOHN CLAYTON BI	rpe, Print)	19b. Mailing	g Address (Street	DOROTHY	WILSO		Zip Code)
Baltimore, M	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		LORRAINE BROOF 20a. Method of Disposition 1 ABurial 2 Cremation 3 F 4 Sonation 5 Other (Specify) 21. Signature of Funeral Service Licens	temoval from State	20b. Place of Dispos cametery, cram. UNION U	M Name and Addre	3/25,	/2006 Nate Water	21678 20c. Location - City on WORTON, Malley Furapolis, M	MD neral
	Physician /Medical Examiner	k	234 Part1. Enter the disease, or completed, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ications that caused the	death. Do not ente	r the mode of dyin	g, such as cardiac or	respiratory arre	apolis, r	Approximate Interval Between Onse, and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury	Due to (or as a co						
P.O. Box 6	death certifi e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 1	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	The law requires that the de ate has been signed by the a page 2 should be detached f	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in the und	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ital Rec	ian: The law rtificate has t	Be Completed	25. Was case referred to medical				26. Place of Death		prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	Attending P ir death. ector: After I by the funera	ertification: To E	examiner? 1 Yes 2 Talko 27. Manner of Death 1 Autural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Yea 28e. Place of Injury	At home, farm, stree	28c. Injury Work M 1 🗆	er: 4 Nursing Hom vat c? Yes 2 No	e 5 Reside 8d. Describe ho	nce 6 Other (Spe w injury occurred	
Ö	To the Hospitel or A within 24 hours after fo the Funeral Dire completely filled in by	edical Cert	29a. Certifier 1 D Cartifying Phys	ician: To the best of my ler: On the basis of exal and manner stated.	v knowledge death	occurred at the time stigation, in my op	ne date and place as	City or Town	, State)	and and
)	To the within To that compli	Σ	29b. Signature and title of certifier	MD			21313		3/20/08	
()	ms		30. Name and address of person who co	415 /1)a	shurton.	Ave-, C	lesterou.			
7. 3.	Sta Registra	ar	31. Date filed (Month, Day, Year) MAR 2 1	2006 D	Para &	South				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** MARCH 18, ROBERT FRANKLIN BURRIS 09:22 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 225 RICHARD DRIVE CHESTERTOWN KENT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth Month, Day, Year) NOVEMBER 14, 1926 **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1∭M 2□F 213-22-8666 79 Yrs. Director MD Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28e-f show treumetic svent, I'm Medical Examinar must be notified at MD KENT CHESTERTOWN Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 RICHARD DRIVE 21620 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 7 Hygiene. permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumetic avent Elementary/Secondary (0-12) College (1-4or 5+) FARMER AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARTHUR H. BURRIS HELEN SHINN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDNA C. BURRIS/WIFE 225 RICHARD DRIVE, CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State CHURCH HILL CEMETERY 03/23/2006 CHURCH HILL, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A 130 SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between aset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading limited in cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sate has I page 2 s autopsy performed? certificate 2 🗆 No Yes 1 Tyes : After this certification, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home ٩ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hesidence 6 □Other (Specify) 27. Manner of real 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Lescribe how injury occurred 28b. Time of Medical Certification: Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation I Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) Name and address of person who come cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) 32. Regiştrar's Signature State Registrar 2006

			For State C		partment of Health and I ertificate of Death	Mental Hygiene Reg. No	000 10001
			Decedent's Name (First, Middle, Last)			2. Date of Death Month Da	y Year
	Physici /Medic		Ruth Edna MacCallum Ber	ryman		March 1	
	Examin	er	4a. Facility Name (If not institution, give street and nu Heritage Harbour Health		4b. City, Town, or Location of Death Annapolis	1 4c	County of Death Anne Arundel
	Funeral Director		5. Social Security Number 273–46–3707 6. Sex 1 □ M 2€0√F	7. Age (In yrs. last birthda 92 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) March 20,	9. Birthplace (State or Foreign Country) 1913 Maryland
	D >		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d, Inside City Limits
	e Maryla e-f ehov	ctor	Maryland Anne Arundel		Severna P		1 ☐ Yes 2 🛣 No
	h with th	ai Director	10e. Street and Number 742 Cypress Road		10f. Zip Code 21146	10g. Ci	tizen of What Country? U.S.A.
36	be filed within 72 hours after death with the Maryland stal Hygiene. id other then "netural", or Iteme 23a or 28e-f ehow event, if a Medical Evanties must be multiled at	by Funerai	Amed F	orces? 2000No ive	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	in 72 hou "netura Judical E	Completed	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occupation ive kind of work done during most of wo a. DO NOT use retired)	rking 16b. K	Kind of Business/Industry
212	i the	E	Elementary/Secondary (0-12) College ((1-4or 5+)	Registered Nurse		Nursing
and ;	9 m 0 >	To Be C	17. Father's Name (First, Middle, Last) Malcolm MacCallum			ne (First, Middle, Maider (unknown)	n Surname)
Mary	ages 1 and 2 should b nt of Health and Ment : If item 27 is marked : or other traumatic e	 	19a. Informant's Name/Relationship (Type, Print) John D. Berryman/son		ailing Address (Street and Number or Ro 3 Sangre De Cristo		
lore,	ages 1 ar		20a. Method of Disposition 1 Burial 2 Coremation 3 Removal from	State cemetery, c	sposition (Name of strematory or other place) coln Crematory 3/1		ocation - City or Town, State
Baltimore,	permit. Pages 1 Depertment of H Important: If its eny injury or ot ong.		4 Donation 5 Other (Specify) 21. Signature of Tuneral Service Licensee	1-11	22. Name and Address of Facility JO	hn M. Taylor	r Funeral Home
	403 e d		23a. Part1. Enter the disease, or complications that		147 Duke of Glouce		Approximate
	Physician /Medical Examiner	ner	Sequentially list conditions b.	racerebro (or as a consequence of):	rul bleed cerei	brovescul	Interval Between Onset and Death Grucci den Fluxes
,0928	The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai Examiner	that initiated events c	o (or as a consequence of):			
P.O. Box 6	that the death certific led by the attending p detached for use as	Physician/Me	23b. Was decedent pregnant 1 Live	gnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	uires that signed b	þ	Part II. Other significant conditions contributing to	death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? □ No 3 □ Probably 4 ÛUnknown
al Records,	ysicien: The law requise certificate hes been a director, page 2 should	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Vit	icien: Th certificate rector, pag	Be	25. Was case referred to medicat examiner?		04 1	ath (Check only one)	- Double (0)
n of Vital	ing Physicien: After this certifica uneral director, I	on; To	27. Manner of Death 1 Natural 5 Pending (Mo	Inpatient 2 ER/Outpar e of Injury onth, Day Year) 28b. Time Injur	e of 28c. Injury at	dome 5 Residence 28d. Describe how inju	
Division	or Attend ifter death Director: in by the i	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined built	ce of Injury - At home, farm, ding, etc. (Specify)		28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medicai Ce	(Check only 2 Medical Examiner: On the		eath occurred at the time, date and plac r investigation, in my opinion, death occ		
	ithin 2 o the	Med	29b. Signature and the of certifier	nner stated.	29c. License number	29d. D.	ate signed (Mgnth, Day, Year)
	⊢ ≯ <u>⊢</u> 3		1 March 1/22	ex mp	D 00295	7/ 3	117/2006
			30 Name and address of person who completed ca	use Cleath (Item 23a) (Typ	pe, Print) ELENSE	Hay Co	FANTO 21111
	Sta	ate	~ ~ ~	Registrar's Signature	1 A	J4, Ca	11100110001117
	Regist	rar	MAR 2 0 2006	Pener S. A	7042)		

			1- State of Maryland / Department of Health and N Certificate of Death		ene) 0 5	10553
			1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	n Day Year	3. Time of Death
	Physici /Medic		SUN AE CHO		17 2006	8.16PM ^M
	Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Deat	h
			SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE		MONTGO	MERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 72 Yrs. Months Days Hours Min.	(Month, Day,	Year) Co	hplace (State or Foreign untry)
	Director			FEB.9,	1934 S	. KOREA
	and	1	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	deeth with the Maryland ime 23a or 28a-f ehow r must be ricillied at	ŏ	MD MONTGOMERY N. POTOMAC			1 X Yes 2 □ No
	288 288	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Co	untry?
	3a or	<u> </u>	15504 QUAIL RUN DR. 20878		U.S.A.	
	deeth	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St	pecify Yes or No-	14. Race - Ame	
9	or ite	Ē	Armed Forces? If Yes, specify Cuban, Mexican, Puerto 1 Never Married 2 Married 1 Yes, 2 No 1 Yes, 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 2	o nican, etc.)	Black, White	
ဗ္ဗ	72 hours after nature!, or ite	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1 ☐ Yes 2 ☐ No Specify:		Specify: AS	T AIN
21215-0036	72 h	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work		6b. Kind of Business/	Industry
2	within ene. than "	d L	Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE		PRIVA	TE
	filed v Hygie other t			ne (First, Middle, N		
and	ntal h	Be			AE	
2	2 should be and Mental is marked of aumatic even	ဥ	CHI YOUNG YANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru			Zip Code)
Maryland	マモトラ		EUN JU CHANG / DAUGHTER 15504 QUAIL RUN			
ē,	permit. Pages 1 and 2 Department of Heelth Important: if item 27 i any injury or other tra ance.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	20c. Location - City or	Town, State
Baltimore,	Pages nent of I ant: If its ury or o		1 U Buriai 2 Light Cremation 3 U Hemoval from State	21/06	ALEX. V	Α
a ti	mit. Parimen parimen sortant: / injury		21. Signature Funeral service Life see 22. Name and Address of Facility AR			
m	Depariment of the part of the		12303 KAYAK DR	UPPER M	ARLBORO	MD 20772
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heert failure. List only one cause on each line.	or respiratory arre	st,	Approximate Interval Between
	Physician			0014		minutes
П	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
1	Cxammer		Immediate Cause (Final disease or condition resulting in death) a. Acute myocardiac Inforct Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of):	tery [); Sease	years
	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	9		•
	and I-tran	хап	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physicien and of for use as the burial-transit					
687	ficate physics the	Physician/Medical	0.			
Box	leath certific attending p	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of del	ivery
ŏ	death e atte d for	ciai	in the past 12 months? 1 Ves 2 Min 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
0		hys	9 Unknown			
s, p	The law requires that the de ste has been signed by the a page 2 should be detached f	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	
ğ	w require been sig should b	ed		1 ☐ Ye	s 2⊠No 3∏Pr	obably 4 Unknown
၁၁	e law re has be je 2 sh	ple		24a. Was ar autops		topsy findings available completion of cause of
œ		Completed		perform	ned? / death?	2 □ No
ita	ician: Th certificete rector, pag	Be (25. Was case referred to medical axaminer?	ath (Check only one	a)	
of Vital Record	tending Physicien: leath. tor: After this certifice the funeral director.	၉	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H		nce 6 □Other (Spe	cify)
Ē		ü.	27. Manner Peath 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
Sic	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	20f Logation (Ct	reet and Number or Re	um I Pauta Alumbar
Division	or Attendent effer deat Director: in by the	ertification;	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town		arai noute ivamber,
_	Hospital 24 hours Funeral etely filled	O	29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place	and due to the ca	use(s) and manner as	stated
	24 h 24 h Fur	edical	(Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.			
	To the Hospital or At within 24 hours effer of To the Funstal Direct completely filled in by	Me	29b. Signa ure and title of certifier 29c. License number	29	9d. Date signed (Mont	h, Dey, Year)
	5		1 Doo58025	5 10	PARCH 1	7 2006
12	, (5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		************	
				ROCKVILL	E MD 20	850
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 2 2096			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March LO: 10 AM **Physician** 2006 Cartee Linda /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2)(2)(F 64 217-40-8425 Director 19, 1941 West Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other treumstic event, the Medical Exeminar must be notified at 1 ☐ Yes 21 No Anne Arundel Severn Directo the 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 1417 Virginia Avenue 21144 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes XXNo White Specify: þ Specify: permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other treumatic event, the Medical Exemple. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Layout Designer Pennysaver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe Swick Treva Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry R. Cartee, Sr. (Husband) 1417 Virginia Avenue, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Meadowridge Mem. Park 3-18-2006 Elkridge, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Date 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cancer Immediate Cause (Final disease or condition LUNG **Physician** /Medical resulting in death) bstructive Pulmonary Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA this is 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 ☐ Pending death. 1 □ Yes 2 □ No investigation 2 Accident the Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 5 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier In 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Gen Burnie, MD. 301 Wispital Drive, Gen Burnie, MD. Jedvas 31. Date filed (Month, Day, Year) . Registrar's Signature State 2006 Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O. I

Division of Vital Records.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 21, Day 2006 **Physician** 1:15 p Archie William Conner, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Marbury 5455 Bicknell Road 8. Date of Birth (Month, Day, Year) July 31,1923 If Under 1 Year
Months Days If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** M 2□ F Hours Washington D.C Months Director 82 562-34-8328 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County Worle rthan "natural", or Itame 23s or 28s-f ehov the Medical Exeminer must be notified at 1 ☐ Yes 2X No Director Maryland Charles Marbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20658 U.S.A. 5455 Bicknell Road by Funeral 12. Was Oecedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐XYes 2 ☐ No Yes. Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Elevator Company Mechanic 10 other 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I Lillian Mae Walter Archie William Conner, Sr. ဥ Department of Heelth and I important: If Item 27 is man any injury or other traumatance. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3304 Captain Dement Dr., Waldorf, Md. 20603 Sandra M. Reese Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) March 24, 2006 3altimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Licenses M00668 4270 Hawthorne Road, Indian Head, Md. 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lead failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ed by the attending physicien and detached for use as the burial-transit certificate be executed Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown certificate has been signed I rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No rmed? 2X No 1 ☐ Yes Division of Vital After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Oate of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation al or Attendi s after death I Director: A d in by the fa 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso OAN KINE CENTER \$207 KANDA M.O. 12070 Louis V. 32. Signature 31. Date filed (Month, Day, Year) State MAR 2 2 Registrar 2006

			1 - For State Registrar	State o	of Marylar		artment of rtificate o			Mental Hy	giene	06	10556
1	Physici		Decedent's Name (First, Middle, Last, Talmage C. Carawan,							2. Date of Da Month March 19	Day	Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give National Lutheran Home		mber)		4b. City, Town	, or Location	on of Death			nty of Death	
Ī	Funeral Director		5. Social Security Number 6. Sec 243-20-3323	K §M 2□F	7. Age (In yrs. 82	last birthday) Yrs.	If Under 1 Yes Months Day		der 24 Hrs. s Min.	8. Date of Bird (Month, Da Sept. 27,	y, Year)	Col	nplace (State or Foreig untry) sylvania
	should be filed within 72 hours after death with the Maryland nd Mantal Hygiene. It marked other then "naturel", or Items 23e or 28e-f ehow umatic event, the Medical Examiner must be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgomer	У		ty, Town or Lo	9						10d. Inside City Limits 1 ☐ Yes 2 🏝 No
	23e or 2	al Dire	10e. Street and Number 11907 Ashley Drive				10f. Zip Code	9 852			10g. Citizen	of What Col	untry?
220	urs after dea st', or Items	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	12. Was Dec Armed Fo 1 13 Yes If Yes, Gr Year or D	2 No ve 1944-		Was Decedent of f Yes, specify C 1 ☐ Yes 2⊠ N	uban, Mexi	can, Puerto	pecify Yes or No Rican, etc.)	8	Race - Amer Black, White ecify: White	•
N-6121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f ehow amportent: If item 27 is marked other then "naturel", or Items 23e or 28e-f ehow injury goother treumatic event, the Medical Examinat must be notified at once.	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College ((Give	dent's Usual Ock kind of work do DO NOT use ret	cupation ne during n ired)	nost of work	king	16b. Kind o		ndustry
מומ ל	uld be filed v lental Hygie ked other t lic event, th	To Be Co	12 17. Father's Name (First, Middle, Last) Benaga Carawan			FTE	ctrician	18. Mo		e (First, Middle, e Spencer	Electr Maiden Surr		
Mary	and 2 shou ealth and M n 27 is mar		19a. Informant's Name/Relationship (Ty Talmage C. Carawan, Jr							nal Route Number NW, #526,			
altıllığı e,	Pages 1 annount of Heisen sint: If item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)				sition (Name of matory or other EMOTIAL P	ark	1	Date n 24, 06	20c. Locatio		
Dall	permit. Departn Importe any inju		21. Signature of Funeral Service Licens	00 ls		Fra 500	Name and Add ENCIS J. O Univers	collin ity Bl	s Funer	al Home : Silver S	Inc oring, M	ID 209	01
,0070	Physician and bhysician and the brutal-transit	dical Examiner	if any, leading to immediate	Due to	(or as a consection as a conse	quence of):				onle			Approximate Interval Batween Onset and Death
.O. DOA O.		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live b	tcome of pregna birth 2 Peta nant at time of c	al death 3	Ectopic pregnal					Date of deli Month	very Day Year
ביים ביים	uires that signed by	by	Part II. Other significant conditions con	ntributing to d	leath but not res	sulting in the u	nderlying cause	given in Pa	art I.	1			the cause of death?
וסטטע	The law req ate has beer page 2 shou	completed	- 14mphoma				194			24a. Was autor perfo 1 Yes		prior to death?	topsy findings available completion of cause of 2 \sum No
SIOH OF VIEW	To the Mospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	ertification: To Be C	27. Manner of Death 1- Natural 5 Pending 2 Accident investigation	28a. Date	·	ER/Outpatien 28b. Time of Injury	28c. In	Other: 4 🔀	(Nursing Ho	th <i>(Check only come 5</i> Residue) Residue	ne) dence 6 □0		ify)
2	ital or Att	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place build	e of Injury - At h ing, etc. (Speci	ome, farm, str fy)	eet, factory, offic	Ç o		28f. Location (S City or Tox		mber or Ru	ral Route Number,
	the Hosp in 24 hou the Fune pletely fil	ledical	29a. Certifier X Certifying Phy: (Check only one) 2 Medicel Exemi	ner: On the b			vestigation, in m	y opinion, o	death occur	red at the time,	date and place	e, and due	to the cause(s)
	10+1	Σ	29b. Signature and title of ceptifier	nell	mi	9	29c. Lice	COO (er 3/2		29d. Date sig March	Z 0	2006
			30. Name and address of person who come address of person who come and address of person who come and address of person who come add	ompleted cau	se of death (Iter	m 23a) (Type,	Print)	4 101	al Lo	Heran	Hono	e Ro	ekulle
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 2 2	2008 32. 5	egistrar's Signa	atur A	MARCH CO.						

			For State Registrar		State o	f Marylaı		artmen rtificate				lental Hyg	giene		05	57
	Physic	ian	1. Decedent's Name (st)							2. Date of Dea Month	ıth Da	y Year	3. Time o	11.000
	/Medi		Hanna Co	hen not institution, aiv	e street and nu	mber)		4b. City,	Town, or	Location		March 1		2006 County of Death	9:35	Α
	Exami	ner	Suburban H			,		Beth						ontgomer	v	
	Funeral		5. Social Security Nur	mber 6.5	Sex I□M 21XIF	7. Age (In yrs	. last birthday)				r 24 Hrs. Min.	8. Date of Birth (Month, Day Dec. 17			place (State ontry)	or Foreign
	Director		219-08-152 Usual Residence of D	24		30	Yrs.					Dec. 1	,19	949 Morc	cco	
	land ow			10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside C	ity Limits
	Mary E sh	ţō	MD N	Montgome	ry	S	ilver S	pring							1 <mark>▼</mark> Yes	2 🗆 No
	th the	irec	10e. Street and Numb	per				10f. Zip	Code				10g. Ci	itizen of What Cou	ntry?	
	th wi	aiD	11150 Oak	leaf Dri	ve			20	901				U. S	S.A		
	ar dez	nue	11. Marital Status		Armed Fo		J.S. 13.	Was Deced If Yes, spec	lent of Hi rify Cuba	spanic O n, Mexica	rigin? (Spe an, Puerto	ecify Yes or No- Rican, etc.)		 Race - Ameri Black, White 	can Indian, etc.	
9	s after	by Funeral Director	1 Never Married 3 Widowed 4		1 ☐ Yes If Yes, Gir Year or D	ve		1 🗆 Yes	2≹ No	Specify	<i>r</i> :			Specify: Whi	ita	
	2 hou	ed		5. Decedent's E	ducation		16a. Dece	dent's Usua	i Occupa	ation			16b. H	Kind of Business/Ir		
ž	Z1Z15-UU36 d within 72 hours att giene, er then "naturel", or the Medical Exami	Completed	(Specify Elementary/Second	dary (0-12)	ade completed) College (1-4or 5+)		kind of wor DO NOT us	rk done d se retired	during mo I)	st of worki	ing				
3	Z Bawit Transport	Con			4		Teach	ier						ucation		
	Baltimore, Maryland 21213-0035 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Exemination to any injury of other traumatic and any once.	Be	17. Father's Name (Fi)							e (First, Middle, Hazan	Maidei	n Sumame)		
	hould d Mer marks	2	19a. Informant's Nam		Type Print)		19h Maili	na Address	(Street :	-			r City	or Town, State, Zi	n Codel	
	Man and 2 s lith and 27 list		Moshe Coh		sband			-				ckville			00000)	1
	Other Head		20a. Method of Dispo			20b.	Place of Dispo					Date		ocation - City or T	own, State	
	Bage Bage	1	1 ⊠ Burial 2 □ 4 □ Donation 5				• Lebai				3/22/	2006	Ade	lphi, MD		
3	Saltimore, sernit. Pages 1 ar Department of Hea mportant: If Item nny Injury or othe		21. Signature of Fund	eral Service Lice	nsée	and the second second							1 F	uneralDi	rectio	n,Inc.
	n ggera		* Tice	wil	le		1	091 R	ockv	ille	Pike	Rockvi	11e	, MD 208	52	
			23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that of one cause on e	caused the dea each line.	ath. Do not en	ter the mod	e of dyin	g, such a	s cardiac o	or respiratory ar	rest,		Approxima Interval Be Onset and	tween
	Physician	0.0	Immediate Cause (Fi disease or condition resulting in death)	inal	Pneum	onia		more.							Oriset and	Dealli
	/Medical Examiner		resulting in death)	(Due to	(or as a conse	quence of):									
		<u>.</u>	Sequentially list cond if any, leading to imm	ditions, nediate	b. Due to	(or as a conse	quence of):									
2	uted d ansit	Examiner	Cause (Disease or in that initiated events	ying ijury												
74	U, exec en an	Exa	resulting in death) La	ıst	Due to	(or as a conse	quence of):				i					
6	68 / 60, cate be executed physicien and the burial-transit	dicai			_ d.											
		Med	IF FEMALE:													
0	BOX seth cer attendin for use	lan/	23b. Was decedent p in the past 12 m	nonths?		tcome of pregr ointh 2 ☐ Fet nant at time of	tel death 3	Ectopic pr						23d. Date of delive Month		Year
20	Hecords, P.O. Box of The law requires that the deeth certific te hes been signed by the attending t age 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☒ ☐ 9 ☐ Unknown	No	9□ Unkn		death 5L	Other (sp	өспу)	rese ===		=1151				
	That ithat in the deta	by Ph	Part II. Other signific		-	eath but not re	sulting in the u	inderlying c	ause give	en in Part	l.	23e. Did to	bacco	use contribute to	he cause of	death?
7	rdS, quires t en signe uld be o		Parkins	on's Dis	sease							1 🗆 Y	es 2	Mano 3 Pro	bably 4 🗆	Unknown
7	BCOFG law requir ss been s 2 should	Completed										24a. Was		24b. Were aut	opsy findings	available
anna	The The Page	E										autop perfor	med?	death? o 1 ☐ Yes	ompletion of a	ause or
वे	ysician:] ysician:] is certifical director, p	Be	25. Was case referre examiner?	ed to medical								h (Check only o				
J.	- Z Z	2	1 ☐ Yes 21 N	lo			ER/Outpatie							6 ☐Other (Special	fy)	
	= -	in oi	27. Manner of Death 1 X Natural	5 Pending		of Injury th, Day Year)	28b. Time of Injury	of A	8c. Injury Work	/at k? Yes 2.[28d. Describe h	ow inju	ury occurred		
Si :	SIC Seatl Seatl tor:	licat	2 ☐ Accident 3 ☐ Suicide	investigation	De Ole Blees	of Injury - At I	home, tarm, st			165 2		28f. Location (S	itreet a	nd Number or Rur	al Route Nun	nber.
HEN	DIVI	Certification;	4 🗌 Homicide	determined	build	ing, etc. (Spec	eify)	1001, 120101)	, 011100			City or Tow				
0	Hospitel or 14 hours afte Funstel Dir tely filled in I													s) and manner as :		e)
0	To the Hos within 24 ho To the Fun completely	Medicai	one)		and man	ner stated.				e number				ate signed (Month,	`	- /
	5 × 5 0		29b. Signature and til	O CONTINUE		C 11	10			195		'		=18-06	∠ay, rear)	
	5		30. Name and address	of parson ut-	completed com	S. Will								10 00		
	•		Dr Ste	ven herson who	Will	<	100 (Type,	in t	foso	steel	Sas	Old Ge	7 ~~ ~	bun ld	Bethes	da rin
		ate	31. Date filed (Month		32.	legistrar's Sigr		melle)	1		-	41-7-00	Ö	A I MILL	208	14
	Regist	rar	` M	AR 22	ZUUD A	But But	10.	A Second Second								,

			For State	State of Maryla		artment of rtificate o				ZUUN	10558
			Registrar 1. Decedent's Name (First, Middle, La	etl		runcate o	Dealli		Re . Date of Death	g. No.	3. Time of Death
	Physici	an	_		.c	r.		1	Month f	Day Yea	ar
	/Medic	al	Vernon Le 4a Facility Name (If not institution, giv		15 5		, or Location	of Death	larch	4c. County of D	
	Examin	er	(a a) d a	2/66 2/1/	126		/			1.1	emico
			5. Social Security Number	Sex, 7. Age (In y	rs. last birthday	Il Under 1 Ye	ar If Under	24 Hrs. 8	Date of Birth		Birthplace (State or Foreign
	Funeral Director		213-36-1341	¹ M ^{2□} F 68	Yrs.	Months Day	ys Hours	Min.	Date of Birth (Month, Day, 9/23/19	937 M	aryland
		d	Usual Residence of Decedent								
	nylan how		10a. State 10b. County		City, Town or La						10d, Inside City Limits
	Sa-f-	cto	Maryland Wicom	100	Bivalve						1 Yes 2 No
	or 24	Funeral Director	10e. Street and Number			10f. Zip Code			10	og. Citizen of What	Country?
	23a	ra	3334 Jesterville			218				USA	
	er de	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Il Yes, specify C	ol Hispanic Ori uban, Mexicar	igin? (Specif n, Puerto Ric	ly Yes or No- can, etc.)	14. Hace - A Black, W	merican Indian, hite, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ No If Yes, Give Ar Year or Dates:	my	1 □ Yes 2 □ X 1	No Specify:	:		Specify:	white
21215-0036	filed within 72 hours after death with the Maryland Hyglene. wher than "naturel", or items 23s or 28s-f show with the Madical Examinar must be notified at	ba	15. Decedent's E		16a Dece	dent's Usual Oc	cupation			16b. Kind ol Busine	ss/Industry
5	in 72	olet	(Specify only highest gr	ade completed)	(Give	kind of work do DO NOT use ret	ne during mos ired)	t of working			our modely
12	than in	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Mec	hanic				Automot	ive
	othe othe	Be C	17. Father's Name (First, Middle, Last)	·		18. Mothe	er's Name (F	First, Middle, N	faiden Sumame)	
<u>a</u>	Ald be read the read	To B	George Henry Co	llins			Mar	garet	Yingli	ing	
Maryland	i 2 should be filed within ? h and Mental Hygiene. 7 is marked other than "! treumatic event, the Mad		19a. Informant's Name/Relationship			-				City or Town, State	
	and 2 Belth a n 27 is		Ardra Marie Coll	ins/wife	333	4 Jeste	rville	Rd.,	Bivalve	e, MD 218	14
Baltimore,	- 도 들 들		20a. Method of Disposition t XBurial 2 Cremation 3		 b. Place of Disposers cemetery, cre 		olace)	Dat	е 2	20c. Location - City	or Town, State
Ĕ	Pages nent of I ant: If Its ury or o		4 □Donation 5 □ Other (Speci	fy)	aryland emetery	Vetera	ns	3/24/	06	Hurlock,	MD
alt	permit. Departrimportri		21. Signature of Funeral Service Lice		al Ho	me Prof	fessional	Association 1804			
01	20559		Novid 7.	Hompson !				1804			
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	pplications that caused the do one cause on each line.	leath. Do not en	ter the mode of o	tying, such as	cardiac or r	espiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Metosta	tiz 1	Rend	Cell	(1	reen 6.	me	Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):	(.,				
		_	Sequentially list conditions,	b. Due to (or as a con	sequence of):						
	led sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	sequence on.						
	and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):						
8760,	cate be executed physicien and the buriel-transit	dical E									
687	ficate physics the	adic		a							
Box	death certifica attending pl d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre						23d. Date of	delivery
ă	death s atte d for	cla	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		⊒Ectopic pregna ⊒ Other (specify,				Month	Day Year
P.0	that the death cert ed by the attendin detached for use	hys	9 Unknown	9□ Unknown							
	The law requires that the death certificate has been signed by the attending I age 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death but not	resulting in the u	underlying cause	given in Part I	1.	23e. Did tob	acco use contribute	e to the cause of death?
Records,	w require been sig should b	ed							1 □ Ye	s 22 No 3□	Probably 4 □Unknown
000	aw requisite the second	Completed							24a. Was an		autopsy findings available to completion of cause of
	The lav	E							perform		1?
ita	sicien: Th certificete rector, pag	O	25. Was case referred to medicat				26. Place	e of Death (Check only one		
>	× 20	ToB	examiner? 1 ☐ Yes 2 No	Hospital:	2 ER/Outpatie	nt 3 DOA	Other: 4□ No	ursing Home	5 🗆 Reside	nce 6 Other (S	Specify)
0 _	ding Pt n. After th funeral	ü	27. Manner of Death 7 □ Naturat 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	of 28c. Ir	njury at Vork?	28	d. Describe ho	w injury occurred	
<u>Si</u>	Attending ir deeth. ector; After by the fune	atle	2 Accident investigation				☐ Yes 2☐	No			
Division of Vital	or Att	ŧ	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of Injury - A building, etc. (Sp	At home, larm, st ecify)	reet, lactory, office	СӨ	28	I. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	00-0-04		1						
	Hosp 24 ho Fund tely fi	Ilca	29a. Certifier (Check only one) Gertifying P Medical Exa	hysician: To the best of my miner: On the basis of exan and manner stated.	knowledge, dea nination and/or ir	th occurred at the rvestigation, in m	e time, date ar ly opinion, dea	nd place, and ath occurred	d due to the ca at the time, da	iuse(s) and manner ite and place, and c	as stated. due to the cause(s)
	To the Hospital within 24 hours of To the Funeral Completely filled	Mec	29b Signature and title ol certifier	and mainer stated.	()	29c. Lic	ense number		29	d. Date signed (M	onth, Dey, Year)
	F ≱ F ŏ		0005	011	MM	1	26-	78		3-7	0-06
	1 Da		30. Name and address of person who	completed cause of death	tem 23a) (Type	Print)	0.00	70			- 0
	02/2		Dought Court MT	Coastal Hos	and P	O. Box	1733	5	S-olish-	. mr	121802
	Sta		31. Date filed (Month Day, Year)	2006 32. Pogistrar's S	ignature				(\mathcal{I}	
	Registr	rar	INIPAIN & &	ZUUD! Alle	A.o.					_	

			For State Registrar		State of Ma	aryland / [ment of H		Mental Hy	/giene	JUD	10559	
,			1. Decedent's Name (Fin	rst, Middle, Last,)					2. Date of D Month	eath Da	y Yea	3. Time of Death	
	Physici /Medio		Rod	BERT	THOI	nas (CHR	ISTOPH	ER			200		
1000	Examir	er	4a. Fecility Name (If not CHESTER R	IVER P	HOSPITAL		R	b. City, Town, or CHE Under 1 Year	STERT			. County of De	7	
	Funeral Director		5. Social Security Number 215-14-07 Usual Residence of Dec	02 128	7. Ag	e (In yrs. last bir 84		onths Days	Hours Mil		10	921 M	Birthplace (State or Foreign Country) Iaryland	
	land ow			. County		10c. City, Tow	n or Locat	ion					10d. Inside City Limits	
	Mary	to	MD	Kent		Ches	tert	own					1 X Yes 2 No	
	or 28s	irec	10e. Street and Number					10f. Zip Code			10g. Ci	tizen of What	Country?	
	238 c	aiD	101 Morg	nec Rd	. Apt. (102		21620	0		U.	S.A.		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28s-f ahow other traumatic avent, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☒ Widowed 4 ☐		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			s Decedent of Hi es, specify Cuba Yes 2/2 No	spanic Origin? n, Mexican, Pue Specity:	Specify Yes or Nerto Rican, etc.)	0-	Black, W	merican Indian, hite, etc. White	
5-0	72 h	ete	15. (Specify o	Decedent's Edu nly highest grad	cation e <i>completed)</i>	16a.	(Give kin	t's Usual Occupa d of work done o NOT use retired	furina most of w	orking	16b. H	(ind of Busine	ss/Industry	
121	within ene. than "	Completed	Elementary/Secondar	y (0-12)	College (1-4or 5			tectua	,	noor	80	1 f E~	ployed	
	Hygie Sther		17. Father's Name (First	, Middle, Last)	2	A	LCIII	tectua		meer ame (First, Middl			ipioyed	
an	ould be Mental harked o	To Be	Joseph C	hristo	pher				Drusi	lla Pe	rkin	s		
, Maryland	1 and 2 should Health and Men 10m 27 is marke ther traumatic		19a. Informant's Name/ Robert L			(son)	36	06 Gre		ng Rd.			e Grace, MD	
altimore,	8 = 5		20a. Method of Dispositi 1 ☐ Burial 2 🙀 Cr 4 ☐ Donation 5 ☐	emation 3 DF	Removal from State		ry, cremat	on (Name of ory or other plac mation		30/06		ocation - City Iyrna ,	or Town, State DE •	
Balt	permit. Pa Departmen Important: any injury		21. Significant Funda	I Servi	20/	M00510	Ga	ame and Addres 1ena F 8 West	uneral	Home G	of S	tephe	n L Schaec	h
15				lure. List only o	ications that caused ne cause on each li	the death. Do	not enter t	he mode of dying	g, such as card	ac or respiratory	arrest,		Approximate Interval Between	
	Physician		Immediate Carse (Fina disease or condition		a Rosi	rivato	vy f	ailuva	2_				Onset and Death	
	/Medical Examiner	8	resulting in death)		Due to (or as	a consequence	of):	4					13	
	9,1	70	Sequentially list condition	ons,	b. Due to (or as	a consequence	45p	1 ra.TIDU	3					
$\sqrt{}$	nsit	in in	Sequentially list condition any, leading to immediate. Enter Underlying Cause Classes or injuries.	1	Dir	ophes	19	7						
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last		Due to (or as	a consequence	of):							-
98760	icate be physicia s the bur	edicai			d	ristla	oula	Juani	5					_
O. Box 6	The law requires that the death certificate be executed to be subjected by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 Yes 2 No 9 Unknown	ths?	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		stopic pregnancy ther (specify)				23d. Dale of Month	delivery Day Year	
, P.O	es that t gned by be deta		Part II. Other significan	t conditions co	ntributing to death b	ut not reşulting i	n the unde	rlying cause give	en in Part I.	23e, Did	tobacco	use contribute	e to the cause of death?	
of Vital Records,	quires n sign ald be	d by	HTN/CA	D./5p	CABG ZX	25/ por	plou	igl Van	cula, D	ا - ح	Yes 2	□No 3□	Probably 40 Unknown	
000	law requires been size should	Completed		*		, ,	•			24a. Wa		24b. Were	autopsy findings available	
æ	The la	E O									opsy formed? 2 20 No	death		
ita	yaiclan: Th is certificate director, pag	Bec	25. Was case referred to examiner?	o medical	1				26. Place of D	ealh (Check only	•			
Ž	S D	ု	1 ☐ Yes ◆ No		Hospital:			3□ DOA Othe	4 🗀 IVUISING	Home 5 ☐ Re			(pecify)	
	Attending Price death.	ation:	27. Manner of Death *** Natural 5 2 \(\text{D} \) Accident	Pending investigation	28a. Date of Inju (Month, Da		Time of Injury	28c. Injury Work	/ at <br Yes 2 □ No	28d. Describe	e how inju	iry occurred		
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director; Atler th completely filled in by the funeral	Certification:		Could not be determined	28e. Place of Inj building, et	ury - At home, fa c. (Specify)	arm, street	, factory, office			(Street a own, Stat		Rural Route Number,	
·	To the Hospitel or Ati within 24 hours after d To the Funeral Direct completely filled in by	edicai (29a. Certifier (Check only one)	Certifying Phy Medical Exam	sician: To the best ner: On the basis o and manner st	t examination ar	e, dealh o nd/or inves	ccurred at the limiting	ne, date and pla pinion, death oc	ce, and due to th curred at the time	e cause(s	s) and manner of place, and o	as stated. due to the cause(s)	
	To the To the Comp	Σ	29b. Signature and title	of certifier	200			29c. License		MD 3			onth, Day, Year)	
	13		30. Name and address	of person who c	1	leath (Item 23a)	(Type, Pri	nt)	in to	MX	2/62	0		
	St	ate	31. Date filed (Month, D			ar's Signature	own	- CHUST	6× (000)	1.LD	, (C) er		***	
	Regist		, , , , , , , , , , , , , , , , , , , ,	, .	006	_	Las	AR D						
DH	IMH 17 Rev 1/2	001	AI	N U J Z	0001	10. Car	-					F		
						OF	RIGINA	l _{res}						

Baltimore, Maryland 21215-0036

LEE CO1 L85	L]		or Print in Black Ir	ndelible Ink. Ensure Al	l Copies A	re Legible.	
			e of Maryland / Dep	eartment of Health and Mertificate of Death	lental Hygie	_	10560
Physici		Decedent's Name (First, Middle, Last) MAE	RDY LEE COLLI	NS	2. Date of Death Month March 29	9, 2006 Year	3. Time of Death 10:13p. M
/Medic Examin		4a. Facility Name (If not institution, give street an Carroll Hospital Cente		4b. City, Town, or Location of Death Westminster		4c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex 212–19–3625	7. Age (In yrs. last birthday	1 1000 1 2000	8. Date of Birth (Month, Day, Y Sept. 21	(ear) 9. Birth	nplace (State or Foreign
		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	Sept. 21	1905 Mar	10d. Inside City Limits
e Maryl te-f eho	ctor	Maryland Carroll Cour	nty Taneyto	own			1 ☐ Yes 2 📉 No
th with the	ai Dire	10e. Street and Number 3271 Old Taneytown Ro	oad	10f. Zip Code 21787		n Citizen of What Co Inited Sta	
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Items 23s or 28s-f show eny injury or other traumatic event, the Medical Examinal must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 If Ye	Decedent Ever in U.S. ed Forces? Yes 2 No s, Give r or Dates:	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
fwithin 72 ho liene. r then "netur ir e Medicel.	Completed	15. Decedent's Education (Specify only highest grade completed the completed specified by the completed specified by the completed specified by the complete specified by the	eted) (Giv life.	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) rentice plumber	ng 16	b. Kind of Business/	Industry
ild be filed lental Hyg ked other ilc event,	To Be C	17. Father's Name (First, Middle, Last) Mark Jason Collins			e (First, Middle, Ma ee McGoni	_	
nd 2 shou alth and M 27 is mai ir traumai		19a. Informant's Name/Relationship (Type, Print Marian Lee Collins		ling Address (Street and Number or Rura 1 Old Taneytown Ro	_	City or Town, State, 2 TOWN, Md.	
t. Pages 1 errent of He rent: If Item		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	Smithsbu	ematory or other place) Apr arg Crematorium	il 4 2006		Town, State , Maryland
Depa Impo eny is		21. Signature of Fyneral Service Licensee	/	22. Name and Address of Facility Sk 36 East Baltimore		eral Home Caneytown,	Md. 21787
Pnysician /Medical		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	that caused the death. Do not end on each line. Multiple use to (or as a consequence of):	nter the mode of dying, such as cardiac of	or respiratory arres	t.	Approximate Interval Between Onset and Death
ecuted and litransit	aminer	cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence of);				
9 ⊏ 12	cai Ex	that initiated events resulting in death) Last	ue to (or as a consequence of):				
The law requires that the death certificate be exate has been signed by the ettending physicien bage 2 should be detached for use as the burial	Physician/Medi	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	ivery Day Year
w requires thet been signed t should be deta	leted by PI	Part II. Other significant conditions contributing	g to death but not resulting in the	underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
sicien: The law re certificate has be irector, page 2 sho	Comp	Of Was and advantage of the state of the sta	Photo:			prior to d	topsy lindings avaitable completion of cause of
hysicier is certif director	To Be	25. Was case referred to medical examiner? 1 XYes 2 No Hospital:	1 ☐ Inpatient 2 ☑ ER/Outpatie	Other	n <i>Check only one)</i> me 5 ☐ Residen	ce 6 □Other (Spec	cify)
r Attending Physicien: er deeth. rector: After this certifica i by the funeral director, p	tification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Date of Injury (Month, Day Year) 29.47 Place of Injury At home, Iarm, spuilding, etc. (Specify)	PM 1□Yes 2 No	28f. Location (Stre	injury occurred Motor / 2/ Out to	vehich

to the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after deeth. To the Funeral Director: After this certificate has been signed by the ettending physicien and Division of Vital Records, P.O. Box 68760, completely filled in

> Medical Cer 29a. Certifier (Check only one) 29b. Signature and title of certifier

Koad

Hughes shop Rd

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Mis

APR 0 5 2006

OCME

29c. License number

111 Penn Street

29d. Date signed (Month, Day, Year) March 30, 2006

Baltimore, Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) min

LING LI 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

			1 - For State Registrar	State of Ma	arylan			nt of H				giene Reg. No.	0.0	6	1056	5 1
			1. Decedent's Name (First, Middle, Las	(t)							2. Date of Dea	ath Day		Year	3. Time of	Death
	Physici /Medic		PAUL DAVID	CRAWFORI)						MARCH	15		2006	1005	М
	Examin		4a. Facility Name (If not institution, give MEMORIAL HOSPITAI				CU.	y, Town, or MBERL	AND			AL	County o			
	Funeral Director		177-32-6207	ex 7. Ag	e (In yrs. I	ast birthday) Yrs.	Month	er 1 Year s Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day JAN • 26	h 2, Year) 5, 193	35]	9. Birthp Coun MARY		Foreign
	and war		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation		-					1	0d. Inside Cit	y Limits
	ours after death with the Marylar rs!', or Itsms 23s or 28s-f show Exercities roust be notified at	ក្ត	MD ALLEGA	ANY	Ct	JMBERL	AND								1 ☐ Yes	X No
	28a	rec	10e. Street and Number				10f. 2	ip Code				10g. Citiz	en of W	hat Coun	try?	
	N with	Funeral Director	15900 WILLIAMS RO	DAD				21502				U.	S.A	•		
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Dec	edent of Hi	spanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	- 1		- Americ	an Indian,	
9	or Its	F	1 Never Married 2 Married	1 Tes 2 1	No			2 X No	Specify:		r tiouri, oto.;		Specify:			
003	within 72 hours after death with the Maryland ene. than "natural", or itsms 23e or 28e-1 show ha Madical Exeminar must be notified at	d by	3. Widowed 4 □ Divorced	Year or Dates:										WHI		
5	nati	lete	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	kind of	ual Occupa vork done d use retired	uring mos	st of worki	ng	16b. Kir	nd of Bus	siness/Inc	lustry	
21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+>			PLOYE				\mathbf{L}^{Z}	AWN	CARE		
d 2	be filed stal Hygi of other svant, i	Be C	17. Father's Name (First, Middle, Last)						18. Moth	er's Name	(First, Middle,	Maiden :	Sumame)		
<u>lan</u>	Aental Aental rked c	To B	CHRISTOPHER CRAN	VFORD					ROS	SE AN	INA GREI	EN				
Maryland	ges 1 and 2 should be filed v t of Heelth and Mental Hygie If Itsm 27 is marked other t or other trsumatic sysnt, ID		19a. Informant's Name/Relationship		TIED OF THE						AMSPOR		_	State, Zip 1795	Code)	
	1 and 1eelth 1m 27 ther to		SAMUEL LEROY CRAN	VEORD/ DROI		lace of Dispo			AD,		Date				wn, State	
5	Pages nent of H int: If Its iry or of		1 ☐ Burial 2 ⚠ Cremation 3 ☐		Cé	emetery, crei	matory o	other place								
Baltimore,	artmer artmer ortant Injury		4 Donation 5 Other (Specify) CUMBERLAND CREMATORY 03/17/2 21. Signature of Funeral Service Licensee 22. Name and Address of Facility										UMBE	KLAN	D, MD	
Ba	permit. Pages 1 and 2 Department of Heelth a Important: If Itsm 27 is sny Injury or other tra once.		Jones P. Lychurch UPCHURCH FUNERAL HOME, P. 202 GREENE STREET, CUMBER											1D 2	1502	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and shock, or heart failure. List only one cause on each line.												Approximate Interval Bety	neev
-	Physician		Immediate Cause (Final disease or condition	a ALZHEIME											Onset and D	eath
	/Medical Examiner		resutting in death)	Due to (or as												
	Examiner	L	Sequentially list conditions,	b. Due to (or as										_		
_	ed isit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience oi):										
	al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):								-		
8760	cate be executed physicien and the burial-transit	dical		d												
9	tificat g phy as th	ledic														
Вох	death certifica e ettending pl ed for use as t	N/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Tectopic	pregnancy				2		of delive		
O. B	0 0 2	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown			Other						Mon	th	Day Y	ear
α.	that the de ted by the c		Part II. Other significant conditions of	ontribution to death b	ut not resu	ulting in the u	ndervin	Cause dive	n in Part I		23e Did to	nhacco u	se contri	bute to th	e cause of de	ath?
of Vital Records,	8 <u>5</u> 8	d by		•			,	•				res (28		3 🗆 Prob		nknown
00	w requir	Completed									24a. Was		24b. W	ere auto	sy findings a	vailable
Re	The law sete has b page 2 sl	E O									autop perfo	rmed?	pr de	nor to cor eath? □ Yes	npletion of ca	use of
ta		0	25. Was case referred to medical						26. Place	e of Death	1 ☐ Yes	2 No	1	162	2 140	
>	S w TO	ToB	examiner?	Hospital: 1 🔲 Inpatie	ent 2	/ ER/Outpatier	nt 3 🗍 I	Othe Othe			me 5 🗆 Resid		Othe	r (Specif))	
	ng Ph Iter th neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	ıf	28c. Injury Work	at ?		28d. Describe h	now injury	occurre	d		
Sio	Attending it death.	catic	2 Accident investigation	1			М		res 2 🗍							
Division	a or Attendir efter death. I Director: Al d in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, et	ury · At ho c. (Specify	me, farm, st /)	reet, fact	ory, office		1	28f. Location (S City or Tox		Numbe	r or Rura	l Route Numb	oer,
_	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Alter th completely filled in by the funeral		29a. Certifier Certifying Ph	ysicien: To the best	of my kno	wledge, deat	h occurre	ed at the tim	e, date ar	nd place,	and due to the	cause(s)	and man	ner as st	ated.	
	hs Ho in 24 i hs Fu pletely	Medical	(Check only 2 Medical Exar	niner: On the basis o and manner st	d examinal	llon and/or in	vestigati	on, in my op	oinion, dea	ath occurr	ed at the time,	date and	place, a	nd due to	the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier					9c. License					-		Day, Year)	
•	2		P (X/4,/			\sim		D0915	/			MARC	H	,200		
	This		30. Name and address obserson who					ERLAN	D. МТ	215	02					
			PAUL SNOW, M.D. 13 31. Date liled (Month, Day, Year)	24 WEST 3R			CULID	TIVIDENI.	111 و <i>د</i>							
	Sta Registi		MAR 1 7 200		ال بي الما											

		Tor State Registrar	State of Man	yland / Depa <i>Cei</i>	artment of I rtificate of	lealth and Death		ene 0 0 6	10562
Dhusisi		1. Decedent's Name (First, Middle, Last)			<u>-</u>		2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic		LESTER ALLEN	CRAWFORD) 			MARCH	12, 2006	3:10 A M
Examin		4a. Facility Name (If not institution, give s DEVLIN MANOR NU		ME		or Location of Dear	th	4c. County of Dea	
Funeral Director		189-30-3515	7. Age (//	n yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days		(Month, Day,	Year) C	thplace (State or Foreign buntry) NSYLVANIA
pur *		Usual Residence of Decedent 10a. State 10b. County	16	Oc. City, Town or Lo	cation				10d. Inside City Limits
Aaryli P eho	5	PA BEDFOR		ARTEMA					1 ☐ Yes 21 No
vith the Marylar or 28a-f ehow	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	1.
th with	<u> </u>	154 PEARL ROAD			1721	1		UNITED	*
within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow he Medical Exeminer must be motified at	Funerai	11. Maritaf Status 1 1 □ Never Married 2X Married	2. Was Decedent Eve Armed Forces? 1 □Yes 2∑No		f Yes, specify Cub	an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	encan Indian,
72 hours a natural", o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	16a, Dece	1 ☐ Yes 2 🛣 No dent's Usual Occur	pation	1	Specify: 1	VHITE
hin 72 on "nu Media	Completed	(Specify only highest grade Efementary/Secondary (0-12)	completed) Colfege (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of wo	rking		
d with	E	12	College (1-401 5+)	AS	SEMBLYM	IAN	н	OME MANU	FACTURING
2 should be filed wi and Mental Hygien ie marked other th aumatic event, Lia	To Be C	17. Father's Name (First, Middle, Last) SPENCER CRAWFO	RD			18. Mother's Na PEARI	me (First, Middle, M CLING		
123 g g		19a. Informant's Name/Relationship (Type LINDA DARLENE CRAN					ural Route Number, ARTEMAS,	City or Town, State, PA 172	
s 1 and 3 Heelth item 27 other tr		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other pla	real .	Date 2	Oc. Location - City or	Town, State
Page lent o nt: if		fX Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		FAIRVIEW			5/2006	ARTEMAS	PA
pernit. Pages 'Department of the Important: if ite any njury or of ans.		21. Signature of Funeral Service/License		22	2. Name and Addre	ess of Facility	RAL SERVI ERETT, PA	CE, INC.	
Private pe executed // Medical Examiner physicien and physicien and the private fransit in the private fransit	dical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on timmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	onsequence of):	ohe	ula de	~	st,	Approximate Interval Between Onset and Death (h.
nding I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	ic. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of de Month	ivery Day Year
w requires that the death been signed by the ette should be detached for	þ	Part II. Other significant conditions conf	ributing to death but n	not resulting in the u	nderlying cause gr	ven in Part I.	10	acco use contribute to	o the cause of death? robably 4 \(\sum \text{Unknown}\)
The law re ate has ber page 2 sho	Completed						24a. Was an autopsy perform	ed? prior to death?	utopsy findings available completion of cause of
ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of De	ath (Check only one	To Assert House Control	20 140
yelclan: nis certific director.	To B	examiner? 1 ☐ Yes 2 ☑ No	ospitaf:	2 ER/Outpatier	it 3□ DOA Ott			nce 6 Other (Spe	cify)
ding Ph th. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Wo		28d. Describe how		
or Atter efter dea Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)			28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
To the Hospital or Attending Phywithin 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral di	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of n er: On the basis of ex and manner stated	amination and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occi	e, and due to the car urred at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)
To th withir	Me	29b. Signature and title of certifier	*		29c. Licens	se number		d. Date signed (Mont	
7) LS		30. Name and address of person who con	npleted cause of deat	h (ftem 23a) (Type,	Print)	626211		21562	
Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's		t				

			For State Registrar	State of Man		partment of F ertificate of			Reg. No.	5 0563
	Physici	an	Decedent's Name (First, Middle, Decedent's Name (First, Middle,					2. Date of Dea	Day Y	3. Time of Death
	/Medio		Ann Roane 4a. Facility Name (If not institution,	Clary give street and number)		4b. City, Town, o	r Location of Death	March	14, 2006 4c. County of	8:45 A M
	Funeral Director		Manor Care Poto 5. Social Security Number 577-46-6862		n yrs. last birthda Yrs.	Potomac y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April	Montgo by Year) 9 5, 1931 W	omery D. Birthplace (State or Foreign Country) Vashington DC
bue	3		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or	Location				10d. Inside City Limits
Marvi	of a la	to	D.C.		_	ton D.C.				1 ŽlYes 2 ☐ No
the ch	r 28a a riotti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
die iw	23a ust b	ral	6307 Utah Ave.			20015			U.S.A.	
rs after de	f Heelth and Mental Hygiene. Item 27 ie marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at	by Funeral	11. Marital Status IND Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? d 1 _ Yes 25 No If Yes, Give Year or Dates;	or in U.S.	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Race - Black, Specify:	American Indian, White, etc. White
	satura Ical E	ted	15. Decedent's (Specify only highest	Education	16a. De	cedent's Usual Occup	ation	vna	16b. Kind of Busin	
ithio 7	hen r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ve kind of work done DO NOT use retired	d) most of work			
iled v	and Mental Hygiene. ie marked other than aumatic event, the M		17. Father's Name (First, Middle, L	5+ ast)	_Li	ibrarian	18. Mother's Nam		Federal F Maiden Sumame)	Reserve System
= 8	ked o	To Be	Roane A. Clary				Alice P			
al yla	e mer		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Ma	ailing Address (Street			er, City or Town, St	ate, Zip Code)
, MI	Heelth tem 27 other tra		J.G. Warfield,							yland 21104
Pages 1	Department of Heel important: if item 2 any injury or other once.		20a. Method of Disposition 15☐xBurial 2 ☐ Cremation	Inditional Itom State		sposition (Name of trematory or other place		Date	20c. Location - Ci	
	ortent injury		4 ☐ Donation 5 ☐ Other (Special Signature) of Funeral Service Li		Union	Cemetery 22. Name and Addre	March ss of Facility Jo	21,06 seph Ga	Spincervi wler's Sc	lle Md.
	o d ma		1 Williams	R. Bugge	_			•		on D.C. 20016
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that caused the	e death. Do not					Approximate Interval Between
	nysician		Immediate Cause (Final disease or condition resulting in death)	a	PNE	UMON	1A			Onset and Death
	Medical xaminer		resulting in dealtry	Due to (or as a c	onsequence of):					
		je l	Sequentially list conditions, if any leading to immediate	b. Due to (or as a c	ons juence of					
cuted	nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
Do by	physician and s the burial-transit	E	resulting in death) Last	Due to (or as a c	onsequence of):					
ficate be ex	phys s the t	edicai		d						
O. DOX of	within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify) _	/		23d. Date of Month	
wrequires thet	n signed by	d by Ph	Part II. Other significant condition		-			1		ute to the cause of death?
	ate hes bee page 2 sho	omplet							osy prio	ore autopsy findings available or to completion of cause of ath?
VII GIAN	ertific ector,	Be (25. Was case referred to medical examiner?				26. Place of Deat			
Physic	this o	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient	2 ER/Outpat		- P□ Nutsing H		dence 6 Other	
oli di	th. After	ton	1 Natural 5 Pending 2 Accident investiga	(Month, Day Y	ea <i>r</i>) Injur	y Wor	k? Yes 2 □No	200. Describe	now injury occurred	
DIVISION OF	s after dea il Director id in by the	Certification:	3 Suicide 6 Could no 4 Homicide determin	ot be 200 Place of Injury	- At home, farm, Specify)	street, factory, office		28f. Location (S City or Tox	Street and Number wn, State)	or Rural Route Number,
he Hospit	in 24 hour he Funera pletely fills	edical	29a. Certifier (Check only one) Certifying	Physician: To the best of r xaminer: On the basis of ex and manner stated	amination and/or	eath occurred at the tir r investigation, in my o	ne, date and place, ppinion, death occur	and due to the red at the time,	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
Į.	Tot	Σ	29b. Signature and title of certifier	0 -	V ^	29c. Licens			29d. Date signed (
	15		P 6	mses.			03/1	-4	3/1	0106
			30. Name and address of person was Truons Bao MI			oe, Print) ark Terrae	co Corre	n frances	Maryland	20074
2	Sta	ate	31. Date filed (Month, Day, Year)				e Germa	HEOWITY !	-aryrand	AU014
	Regist	rar	MAR 21	2006	Signature	BES SE				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year 18, 2006 Douglas March 2:30 a M Bryant Crowe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8500 St. Andrews Chesapeake Beach Calvert Drive If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) **Funeral** 1**X** M 2 ☐ F 50 Director June 11, 1955 Washington, DC 217-64-9929 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10d. Inside City Limits worde r then "natural", or items 23a or 28a-1 ehov tre Medical Examinar must be rotified at 1 ☐ Yes 2 X No MD Calvert Chesapeake Beach Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whai Country? 8500 St. Andrews Drive 20732 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ 3 ☐ Widowed 4 ☑ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 kitchen technician school system 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If Item 27 is marked o eny Injury or other traumatic eve Clarence **Bryant** Crowe, Jr. Ruth Sydnor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8500 St.Andrews Dr., Chesapeake Beach, MD 20732 Colt B. Crowe, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Rempval from State So. Memorial Gardens 03-21-2006 Dunkirk, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility uloa a Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocard /Medical Due to (or as a consequence of): Examiner 500 CC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sit The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Iclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Physi 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Donknown 1 ∏Yes 2 ∏No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1□ Yes 2 110 25. Was case referred to medical exampler? Be 26. Place of Death (Check only oge, examiner 1 Yes Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this 27. Manno of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After t 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 person who completed cause of death (Item 23a) (Type, Print) Kayman 111 No DX 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 21 2006 Registrar

			for State State Registrar		artment of Health and I rtificate of Death	Mental Hygie Reg.	to U U U	10567
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Dorothy M. Dero		41 O't To 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	March 17		11:35 p ^M
	Examin	er	4a. Facility Name (If not institution, give street and Southern Maryland Hos		4b. City, Town, or Location of Death	1	4c. County of Death	
	AT	Щ		-	Clinton If Under 1 Year If Under 24 Hrs.		Prince Ge	
	Funeral		5. Social Security Number 6. Sex 1 M 2 M 2 M	7. Age (In yrs. last birthday) F 70 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month, Day, Ye	ear) 9. Birthp	place (State or Foreign ntry)
1 4	Director		Usual Residence of Decedent	70 Yrs.		July 27,	1935 Fran	klin, La.
	and		10a. State 10b. County	10c. City, Town or Lo	cation		1	10d. Inside City Limits
	Aanyl ehe	ō	Maryland Prince George	es Ft. Wasi	hington			1 Tyyes 2 □ No
	28a-	Director	10e. Street and Number		10f. Zip Code	100	. Citizen of What Cour	2-2
	death with the Maryland ms 23a or 28a-1 ehow rmust be rotified at		2506 Kingsway Rd.		20744			•
	eath	era		Decedent Ever in U.S. 13. V			Jnited Sta	
20	hours after death with the Marylan kurel', or Items 23a or 28a-1 ehow at Examiner must be notified at	by Funeral	1 ☐ Never Married 2 🔀 Marned 1 ☐ Y	es 2 🛣 No , Give	Mas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert I ☐ Yes 2栞No Specify:	o Rican, etc.)	Black, White,	etc.
12-0036	E 2 4	ed b	15. Decedent's Education	or Dates:	dent's Usual Occupation	161	b. Kind of Business/Inc	
Ď	within 72 ene. than "na'	Completed	(Specify only highest grade complet	ed) (Give	kind of work done during most of wor DO NOT use retired)	king	o. Kind of businessym	austry
7	with ene.	E	Elementary/Secondary (0-12) Colleg	18 (1-40r5+)	OA Supervisor		Federal Gov	
0	filed Hygin ther ant, I		17. Father's Name (First, Middle, Last)	OBI		ne (First, Middle, Mai		/ernment
/ian	should be and Mental smarked c	To Be	Earl James		Mary B			
a	and la ma		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru			Code)
Σ.	and a	1	Cleveland J. Derouen	-	Kingsway Rd. Ft.	Washingto	on, Md. 20	0744
<u> </u>	of He		20a. Method of Disposition	20b. Place of Dispo	sition (Name of natory or other place)		c. Location - City or To	
Ē	age ent ent: f y o		1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)			5/2006 J	leanerette,	, La.
Baltimol	permit. P Depertme Importer any njure		21. Signature of Funeral Service Ligensee	N 0102 22	Name and Address of Facility Llexander S. Pope 538 Mariboro Pik	Funeral H	lomes, P.A.	2007/7
	J. 3	-		at caused the death. Do not ent	sthe mode of thing such as cardiag	e/ FOIestvi	ille, Ma.	20747 Approximate
			23a. Part1. Byter the disease, or complications the shock, or heart failure. List only one cause	on each line.		or respiratory arrest,	•	Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	T Lyng /	neymonia.			700
	/Medical Examiner		Due	to (or as a consequence of);	011			-
	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1		Securitally list conditions b.	+ reluva	1 Thus			+0-x
	ed sit	lne	S x unitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):	- V			Maria Salar
	and I-tran	Examine	triat initiated events	to (or als a consequence of):	A -			3 1/
Š	cien cien ouria	E E	. 500	TO (or as a consequence or).				·
09/90	cate l	edlcal	d					
o X	ding t	Me	IF FEMALE:					
X D D	eath certificate be executed attending physicien and for use as the burial-transit	lan/	in the past 12 months?		Ectopic pregnancy		23d. Date of delive Month	ery Day Year
- -	the death certificate be executed y the attending physicien and iched for use as the burial-transit	Physician/M	1 Yes 2 TNo 4 P	regnant at time of death 5 🗆 nknown	Other (specify)			July 10al
7.	hat the d by detac	P.	Part II. Other significant conditions contributing t	o doub but not regulating in the	adadda a an a la Badi	an Didasha		
cords,	w requires that the de been signed by the should be detached	ed by	Part II. Other significant conditions contributing i	o death but not resulting in the ur	cerrying cause given in Part I.	1 ☐ Yes	co use contribute to the	ably 4 Unknown
	law re as bee 2 sho	ompleted				24a. Was an	24b. Were auto	psy findings available
T C	0 - 0	E				autopsy performed	d? prior to cor death?	mpletion of cause of
	sicien: Th certificate rector, pag	Ö	25. Was case referred to medical	The second second	OC Olean al Dan	1 ☐ Yes 2-√2	No 1 ☐ Yes	2∐ No
>	Physicien: this certific ral director,	o B	examiner? Hospital:	VInpatient 2 ER/Outpatien	04	th Check only one		
5	iding Phyeicien: th. : After this certifica i funeral director, fo	\vdash		ate of Injury Alonth, Day Year) 28b. Time of Injury	4 Nuising H	28d. Describe how i	e 6 Other (Specify	0
0	ding th. Afte	흗	1 VNatural 5 ☐ Pending (A 2 ☐ Accident investigation	fonth, Day Year) Injury	28c. Injury al Work? M 1 ☐ Yes 2 ☐ No		. ,	
DIVISION OF	Atten dea ctor y the	flca	3 Suicide 6 Could not be 28e, P	ace of Injury - At home, larm, stre		28I. Location (Stree	and Number or Rura	I Boute Number
É	a after f Dire d in b	Certification:	4 Homicide determined by	ulding, etc. (Specify)		City or Town, S	State)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical ((Check only 2 Medical Examiner: On th	the best of my knowledge, death e basis of examination and/or inv nanner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the caus	e(s) and manner as st and place, and due to	ated. the cause(s)
	o the o the omple	Me	29b. Signature and title of certifier		29c, License number	29d.	Date signed (Month,	Day, Year)
	- s - ō		1/1/2		1)-74526		7 10 0	/
)	(VVIV		0 61373	0	7,10,6	6
_	15/	}	30. Name and address of person who completed of Laxmi Berma, M.D.			10 EW a	7725	
- dia	C			Registrar's Signature	Ave. #101 CLinto	11, Ma. 20	0735	
	Sta Registr		MAR 2 2 2096	Due & Sea	BI			

			For Stata Registrar		State of	of Maryla	and / Dep	artment rtificate			and M		Reg. No.	106	Total Control of the	68
	Physici		1. Decedent's Name (First, Mi			DiNof	ia					2. Date of Dea Month March	ath Day 28	2006	3. Time of 2205	Death P M
,	/Medic Examin		4a. Facility Neme (If not institu				ru	4b. City, 7	Town, or	Location	of Death	1101		ounty of Death		
	Xuiiiii	.	Calvert Man	or He	ealthc	are Ce	nter			Sun				Cecil		
	Funeral Director		5. Social Security Number 161-10-7485	6. Set	M 2∏F	7. Age (In ye	rs. last birthday) Yrs.	Months Months	1 Year Days	tf Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da JAN 4,	h y, Year) 1911	9. Birth Con Po	nplace (State o untry) land	or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. Cou	nty		10c.	City, Town or L	ocation							10d. Inside Ci	ity Limits
	Mary I-f sh	ţ	Maryland Ce	ci1			Rising	Sun							1 🗌 Yes	2 ∑ No
	th the	Director	10e. Street and Number					10f. Zip	Code				10g. Citize	n of What Co	untry?	
	ath wi	rail	1881 Telegr	aph I					911					ted St		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its MacJoal Eracitical monthe rolling at anone.	by Funerai	11. Marital Status 1 □ Never Married 2 □ M 3 ☑ Widowed 4 □ Divor-		Armed F	2∭XNo ive	10.S. 13.	Was Deced If Yes, spec		ispanic Ori in, Mexicar Specify:		ecify Yes or No Rican, etc.)		Black, White		
9	2 hou atura	ted	15. Dece	lent's Edu	cation		16a. Dece	dent's Usua	l Occupa	ation	at at want		16b. Kind	of Business/l		
215	thin 7.	pje	(Specify only high Elementary/Secondary (0-1			(1-4or 5+)		kind of wor DO NOT us		during mos ()	t or work	ng		0		
2	led wi	Be Completed	17. Father's Name (First, Midd	tto t and)			Но	memake	er	19 Moth	or's Nome	First, Middle,		Her Ow	n Home	
and	d be fill antal H ted otl	o Be	Peter Kokod		i						know		Maidell 3	umame)		
N.	should nd Me mark	2	19a. Informant's Name/Relati				19b. Mail	ng Address	(Street a			al Route Numbe	er, City or	Town, State, Z	ip Code)	-
Ž	alth a straight a stra		Charles DiN	ofia,	/Son		194	Master	s C	irc1e	, Sa	nta Ros				
Baltimore, Maryland 21215-0036	ges 1 of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremati	on 3 □F	Removal from	State S	o. Place of Disp cemetery, cre aints P	osition (Nameratory or ot	ne of ther plac and		Apri	late 1,	Spri	ngfiel	Town, State ${ m d}$,	
Ē	it. Paurtmen		4 ☐ Donation 5 ☐ Othe 21. Signature of Funeral Serv			P.	aul Cem	etery			2006			sylvan		
Ba	Depa Impo any ii	3	Donard	<u>.</u>	Die	Cash	I	licks .03 W.	Home Sto	e for	"Fune n Sti	erals, l reet, E	P.A. <u>1kton</u>	, Mary	land 21	921
			23a. Part1. Enter the disease shock, or heart failure.	, or compl List only o	ications that ne cause on	caused the de each line.			e of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximat Interval Bet Onset and I	ween
E	Fnysician /Medical	ñ	tmmediate Cause (Finat disease or condition resulting in death)	-	a	o (or as a cons	-	Whole ,	H							
	Examiner				b.	(or as a cons	sequence or):									
7	po iis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Į		(or as a cons	equence of):									
/	xecute and ai-trans	Examiner	that initiated events resulting in death) Last		c	(or as a cons	sequence of):									
8760,	ysician ysician	icai E			d											
9	rtifica ng phy s as th		IF FEMALE:													_
.O. Box	that the death certificate be executed ned by the attending physician and detached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Male		1 🗆 Live	utcome of pre birth 2 F gnant at time o nown	etal death 3	⊒Ectopic pro ⊒ Other <i>(sp</i> e					23	d. Date of deli Month	-	Year
Δ.	res that the igned by th be detache	by Ph	Part II. Dther significant con	ditions co	ntributing to	death but not	resulting in the	underlying ca	ause giv	en in Part I	l.	23e. Did t	obacco us	e contribute to	the cause of c	death?
Ş	law requires as been sign 2 should be							· · · · · · · · · · · · · · · · · · ·				10'	Yes 2□	No 3□Pr	obably 1	Jnknown
i Records,	The ate h page	Completed			*********							24a. Was autor perfo		24b. Were au prior to death?	topsy findings completion of c	available ause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to med examiner?	1	-loonital:				Oth		e of Deatl	n (Check only o	one)			
of	Phyaician: r this certific ral director,	5	1 ☐ Yes 2 ☐ No 27. Manner of Death				P.□ ER/Outpatie			XNI	-	me 5 Residente la			cify)	
O	ding After fune	tion	Natural 5 Pe	nding estigation	(Mo	of Injury nth, Day Year	njury	M	8c. Injun Worl	k? Yes 2□		200. 20001120	non myary	00001100		
Division	or At fter o pirect in by	Certification:	3 Suicide 6 □ Co	uld not be ermined	28e. Plac	ce of Injury - A ding, etc. (Sp	t home, farm, s	treet, factory	r, office			28f. Location (: City or Tox		Number or Ru	ral Route Num	nber,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai C			ner: On the		knowledge, dea nination and/or i									6)
}	To th within To th compl	Me	29b. Signature and title of ce	iger	0 /	Beari	No M	290	. Licens	e number	00		29d. Date	signed (Moht)	h, Day, Year)	
	11		30. Name and address of per	son who	ompleted car	use of death (Item 23a) (Type	. Print)	ed sa	51	82	MIA Q	115	111 -	1411	
	Str	ate	31. Date filed (Month, Day, Y	9ar)	32	Registrar's Si	gnature	v. M	4110	119	NI	ve po	10/1	rul jok	/ ///	
	Regist		APR 0	5 20	06	sen.	st A									

		•	For State Registrar			•		lealth a	nd Mental Hy		06	1056	9
	Physicia	an	1. Decedent's Name (First, Middle	· ·					2. Date of D Month	Day	Year	3. Time of D	
	/Medic	al	ETHEL		VIS		Ab Ciby Town	al applies of	MARCH		anty of Death	1137	M
	Examin	er	4a. Facility Name (If not institution fund) WSULA REGIO		del 1	12.41	4b. City, Town, o	NIS bu	Mean Maria	40. 000	Wico.		
	Funeral		5. Social Security Number	6. Sex 7. A	ige (In yrs.	last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of B	irth	g. Birth	place (State or	Foreign
	Director		043-16-0777	1□M 2∏F	83	Yrs.	Months Days	Hours	JAN 2	2, Year 92	3 61	(ntry)	
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation	-				10d. Inside City	Limits
	Maryl	lor	MD WIC	OMICO	S	ALISBU	RY					1 Ty Yes 2	
	r 28a	Director	10e. Street and Number	011200			10f. Zip Code			10g. Citizen	of What Cou	untry?	
	th with	ai D	6875 LOIS A	VE.			2180)4		USA			
	r dea	Funerai	11. Marital Status	12. Was Deceder Armed Forces	?	.S. 13.	Was Decedent of H Yes, specify Cub	lispanic Orig an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0- 14.	Race - Amer Black, White		
36	rs afte	by F	1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 24 If Yes, Give Year or Dates			□ Yes 🎾 No	Specify:		Sp	өсіfу: WH	IITE	
Ö	2 hou	ted	15. Deceden	t's Education		16a. Deced	lent's Usual Occup	pation	-44.!	16b. Kind	of Business/I		
215	thin 7	Completed	(Specify only highes Elementary/Secondary (0-12) 12	College (1-4o	r 5+)		kind of work done OO NOT use retire	during most d)	or working				
7	led wi lygien her th	Con		1		INSPE	CTOR	40 44-15	4- No (Fine Asida)		CTRONI	CS	
Maryland 21215-0036	ould be filed within 72 hours after death with the Marylend Mental Hygiene. and dother than "naturel", or iteme 23a or 28a-f ehow atte event, the Modical Exarchar must be notified at	Be	17. Father's Name (First, Middle, LOUIS ZAM						's Name <i>(First, Middl</i> i EL VERES	e, Maiden Sui	name)		
Ž	should nd Me mark matic	٦	19a. Informant's Name/Relations			19b. Mailir	g Address (Street	l	or Rural Route Num	ber, City or To	own, State, Z	ip Code)	
Z	elth a		DAVID E. DAVIS	- Son		6875	LOIS AVI	E., SA	LISBURY, M	D 2180	4		
ore,	of He of He r other		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation	3 Tigomoval from Stat		emetery, crer	sition (Name of natory or other pla		Date		ion - City or 1		
Ĕ	Pag ment tant: f jury o		4 Donation 5 Other (S		* ALL		S CEMETER		4-4-06	NORT	H HAVE	EN, CT	
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Heelih and Mental Hygiene. Inteportment of Heelih and Mental Hygiene. Inteportment: If them 27 is marked other than "naturel; or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Exactival must be notified at Once.		21. Signature of Funeral Service	- 1			Name and Addre		SHOKI FU			CES	
			Heorge in 23a. Part1. Enter the disease, or		ed the deat				., MILTON,		908	Approximate	
7	-		shock, or heart failure. List Immediate Cause (Final	only one cause on each	line.			17				Onset and De	eath
	/Medical		disease or condition resulting in death)	a. Due to (or a	is a conseq	uence of):	1 Harmes	C				1-20,75	•
П	Examiner		Sequentially list conditions	a. MULT Due to (or a b. Colland Due to (or a	Nay	ALIERY	BIPKSS	JURGE	24			ZOUFERC	5
	pe #s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									45195	
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	U	is a conseq		0. SPASE		-1			(61-	
760,	e be e	calE		L d.									
89	ng phy as th		IF FEMALE:										
Вох	The law requires that the death certifica 11e has been signed by the attending ph 2ge 2 should be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	ldeath 3□	Ectopic pregnanc	у		23d	. Date of deli	,	ar
P.O.	the a	ysici	1 Yes 2 No	4□Pregnant 9□Unknown		leath 5□	Other (specify) _				WORK	Juy	201
٥.	that the object of the object	/ Ph	Part II. Other significant condition	ons contributing to death	but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of de	ath?
rds	w requires that s been signed b should be deta	d b							1	Yes 2□N	lo 3□Pro	obably 4 Ur	nknown
CO	s bee	Completed							24a. Wa		4b. Were au	topsy findings a	vailable
Ä	The law ate has bage 2 s	mo							per	opsy formed? 2 K No	death?	completion of car 2 No	use or
Vital Records,	Physicien: The I this certificate har ral director, page	Be (25. Was case referred to medica examiner?						of Death (Check only				
_	두 두 등	To	1 ☐ Yes 2 12 No 27. Manner of Death	Hospital: 1 X Inpa 28a. Date of Ir		ER/Outpatier	IL 3 DOA		rsing Home 5 Re	sidence 6 [e how injury o		cify)	
O	ding h. After funer	tlon	1 Natural 5 Pendir 2 Accident investi	ng (Month, I	Day Year)	Injury	Wo	rk?]Yes 2∐1		e now injury o	ccurred		
visi	Attending r death. ector: After oy the fune	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of			eet, factory, office		28f. Location		lumber or Ru	ıral Route Numb	er,
Division of	s after al Dire	Certification:	4 Homicide	building,	etc. (Specil	(y)			City or 1	own, State)			
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer		(Check only 2 Medical	ng Physician: To the be Examiner: On the basis	of examina	owledge, deat	n occurred at the ti	me, date and	d place, and due to the	e cause(s) an	d manner as	stated. to the cause(s)	
	within 2 within 2 To the complet	Medical	one) 29b. Signature and title of certifie	and manner	stated.		29c. Licen					h, Day, Year)	
	8 1 % 1) (anos	13/1			D53				-	ZOOG	
•			30. Name and address of person	- /	f death (Iter	n 23a) (Type.		1001		,			
			James Todd	100E. Carrol				21801					
	Sta		31. Date filed (Month, Day, Year,		strar's Signa	ature	W. Marine						
DH	Regist		APR 0 4	2006	All d	the party	242)						-
υH		100				ORIGI	NAL						

Ethel DAVIS 043-16-072

			1- State of Maryland / Department of Health a Certificate of Death			iene	05	10570
4	×		Decedent's Name (First, Middle, Last)	2.	Date of Death	n .		3. Time of Death
	Physici		Harold Cecil DeWitt		Month O3	Day 19	O G	0955 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location			4c. Coun	ty of Death	
			Sacred Heart Hospital Cumberla	ind		Alle	gan	Y
	Funeral		5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) tf Under 1 Year If Under		Date of Birth (Month, Day,			place (State or Foreign
	Director		214-36-6833 X 64 Yrs.		eb. 3,	1942		land
	pur &		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
	eho	ō						1 ☐ Yes 2 ☑ No
	the A	Director	MD Garrett Oakland 10e. Street and Number 10f. Zip Code		10	og. Citizen of	f M/bat Cou	
	with a						_	•
	death with the Maryland ime 23a or 28a-f ehow Croust be notified at	Funerai	411 LeMoyne King Road 21550 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori	rigin? (Specify		United 14. Ra	ace - Ameri	
0	effer death with the Marylan or Iteme 23a or 28a-f ehow crinet must be nutilled at	필	Armed Forces? tf Yes, specify Cuban, Mexican	ın, Puerto Rici	an, etc.)		ack, White,	
2-003p	72 hours efter de: "netural", or Iteme idical Examiner m	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 ☒ No Specify:	·:		Spec	wh:	ite
ָ ה	"netural",	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mos	st of working	1	16b. Kind of	Business/Ir	ndustry
7	within 72 ene. then "ne	npie	Etementary/Secondary (0-12) College (1-4or 5+)	or or working				
7	D D = -	ပိ	8 Roof Bolter			Coal 1		
yland	d is b	Be			irst, Middle, M		ıme)	
С.	should by nd Menta marked imaric ev	2			e Sauc			
Z Z	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Linda DeWitt 411 LeMoyne King					Code)
a)	Head Head		20a Mathod of Disposition 20b Place of Disposition (Name of	Date		20c. Location		own. State
2	Pages nent of int: if it		Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)	2/				
Saltimol	in property		4 □ Donation 5 □ Other (Specify) Garrett Memorial Gard 21. Signature of Funeral Service Licensee 22. Name and Address of Facili			0akla		
ŭ	Ped Per Ped			Darac	ock-Dui			Home 21550
			21 N. Second 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as				rii)	Approximate
	Object to the last		shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a)			-	3 dogs
	Examiner		there Renot lasture				10	500
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying					1
	cuted nd ransi	Examin	Cause (Disease or injury that initiated events					10 40 .
Š	e exe ien al urial-1		resulting in death) Last Due to (or as a consequence of):					1
2/eU	icate be executed physicien and s the burial-transit	dicai	d					
٥	death certific attending p	D 0	IF FEMALE:				Į.	
X Q	attend for us	ian	23b. Was decedent pregnant in the past 12 months? Solution				Date of deliv Aonth	ery Day Year
j	law requires that the death as been signed by the atter 2 should be deteched for u	Physician/M	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)					
ī.	that ed by dete	F.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	1.	23e. Did tob	acco use co	ntribute to	the cause of death?
cords,	uires sign	d by	Hyper Volesie, De Toy Not Compliance		1	s 2 No	3 🔲 Pro	bably 4 Unknown
	w req	ete	Debecco gestile		24a. Was ar	n 24h	Were aut	opsy findings available
ě	0 2 0	Completed	Depository Cognitor (100)		autopsy	y ned?	prior to co death?	empletion of cause of
g	sician: Th certificate rector, pag	0	25. Was case referred to medical 26. Place	e of Death //C	1 ☐ Yes 2	-	1 🗌 Yes	2 □ No
<u> </u>	ysici is cer direct	, B	examiner?		5 ☐ Reside	***	ther (Speci	fv)
ם ר	ig Ph ter th neral	n: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		l. Describe ho			<i></i>
<u> </u>	endir sath. or: Af	ation:	Accident investigation M 1 Yes 2]No				
UIVISION	r Att	Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (Sti City or Town		nber or Run	al Route Number,
_	urs of urs of ral D	S						Date of the second
	Hosp 24 ho Fune Fune	edicai	29a Certifier (Chack only one) 1. Certifying Physician: To the basis of examination and/or investigation, in my opinion, dec and manner stated.	nd place; and ath occurred a	due to the ca at the time, da	itte and place	named act	taled. to the cause(s)
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director.	Med	29b. Signature and title of certifier 29c. License number		29	9d. Date sign	ned (Month.	Day, Year)
	- s + ŏ		D 19	7318		More	1 10	7th 9001
			30, Name and address of person who ampleted cause of death (ttem 23a) (Type, Print)	210	1	110-10-		6.6
			Dr. Nagaratnam Ranjithan, 517 Oldtown Road, Co	umberl	and h	tasula	and -	1500
7.	Sta		31. Date filed (Month, Day, Year) U32. Registrar's Signature	V. H.)	1410	-115/1. 34	The state of the s
1	Registr	rar	MAR 3 2 2008					

ORIGINAL

			1 - For State Registrar	State of	Marylan		artment rtificate			and M	lental Hy	giene Reg. No.)06	057
	Physici	20	1. Decedent's Name (First, Midd								2. Date of De. Month	Day	Year	3. Time of Death
	/Medic		Evelyn	Mae		iggs	T				March			1:55 P M
1	Examin	er	4a. Facility Name (If not institution						Location of				ounty of Dea	
			Harbour Crest 5. Social Security Number		Home 7. Age (In yrs. I	last birthdav)	S1	lver Year	Spr If Under	ing 24 Hrs.	8. Date of Birt	h	ntgome	thplace (State or Foreign
	Funeral Director		028 20 5352	1 ☐ M 2 🖺 F	94	Yrs.	Months	Days	Hours	Min.	Dec. 2	Year 19	11 Ma	issachusetts
	D		Usual Residence of Decedent											
	arylar how	<u>.</u>	10a. State 10b. County	′		, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 No
	Se-f	Director		gomery	Si	lver S								
	hours after death with the Maryland turel', or Itema 23e or 28e-f ehow al Examinationual be modified at		10e. Street and Number	abda Ddha			10f. Zip (208	07			10g. Citize	n of What C	ountry?
	eath	Funeral	12801 Old Colum		dent Ever in U.	S 13	Was Decede			oin? (Spi	activ Yes or No	. 14		erican Indian,
10	fler d	Ξ	1 Never Married 2 Mar	Armed For	ces? 2 XX No					, Puerto	ecfy Yes or No Rican, etc.)		Black, Whi	te, etc.
03	rel', o	þ	3 Widowed 4 ☐ Divorce	If Yes, Give Year or Da	tes:		1 ☐ Yes 2	No	Specify:			S	pecify: L	Black
21215-0036	2 E H	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	dent's Usual kind of work	done o	lurina most	t of work	ing	16b. Kind	of Business	/Industry
121	within ene. then	ig m	Elementary/Secondary (0-12)	College (1-	4or 5+)		DO NOT use)				Own Ho	·mo
2	0.00		12 17. Father's Name (First, Middle,	Last)		НС	memak	er	18. Mothe	r's Name	(First, Middle,			лше
Maryland	d la b	To Be	John Roseme								Diggs		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
37	2 shoul and Ma is mari eumati	F	19a. Informant's Name/Relation.	ship (Type, Print)		19b. Maili	ng Address (I Route Numbe	er, City or T	own, State,	Zip Code)
	as 1 and 2 should of Health and Me Item 27 is mark cother treumation		James A. Digg	s / Son		7214	Pinev	Woo	ds Pl	lace	Laurel.	. Mar	vland	20707
Baltimore,	S S S S S S S S S S S S S S S S S S S		20a. Method of Disposition 1 Burial		-	lace of Dispo	sition (Name	e of			Date			Town, State
Ĕ	Page Int.		4 Donation 5 Other (Dav	is Fun	eral l	Home	3	3/25	/2006	Roxb	ury,Ma	ssachusetts
Salt	permit. Pages 1 Department of H Important: If its eny injury or of		21. Signature of Funeral Service	Lipensee	1						s Rina			
_	E = 202		Jane !	remo	Dun								Sprin	ng,MD 20904
			23a/Part1. Enter the disease, of shock, or heart failure. Lis	r complications that ca t only one cause on ea	used the death ich Me.						or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	olon	6	rici	un	a					Zys
	/Medical Examiner		resoluting in dealth)	Due 197	r as a consequ	uence of):	car		0 4					Hims
		<u>.</u>	Sequentially list conditions,	b. Due to (or as a consequ		Cov	n u		-				70
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	~	·	,								
oʻ.	exec an en	Exa	resulting in death) Last	Due to (or as a consequ	uence of):								
8760,	sate be executed obysicien end the burial-transit	lical		d.										
9	death certificate be executed e attending physicien end nd for use as the burial-transit	Med	IF FEMALE:											
Вох	eath ce attendi for use	lan/	23b. Was decedent pregnant in the past 12 months?		rth 2 Fetal	death 3	☐Ectopic pre					23	d. Date of de Month	livery Day Year
	at the dea by the a stached fo	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊟Pregna 9⊟Unkno	ant at time of de wn	eath 5	Other (spe	cify)					Month	Day Tour
P.0	law requires that the es been signed by th 2 should be detache		Part II. Other significant conditi	ions contributing to de	ath but not resu	ulting in the u	nderlying ca	use cive	n in Part I		23e. Did to	obacco use	contribute t	o the cause of death?
Vital Records,	uires sign d be	d by	Asthma				,				10	res 2	6 3 □ P	robably 4 Dunknown
Ö	w requir been si should	lete	1								24a. Was	an	24h Wara a	utopsy findings available
Be	The la ete hes page 2	Completed	· · · · · · · · · · · · · · · · · · ·								autor perfo	sy reped?	prior to death?	completion of cause of
a	en: T tificet tor, pa	0	25. Was case referred to medica	ai					26 Place	of Death	1 Yes	2 100	1 L Ye:	s 2 No
<u> </u>	Physician: this certific ral director,	0 8	examiner? 1 ☐ Yes 2 No	Hospital:	patient 2	ER/Outpatier	nt 3 DOA	Othe	\r-	rsing Ho			☐Other (Spe	ecity)
J of	Jing Ph I. After th funeral	i.c	27 Manner of Death Natural 5 ☐ Pendi	28a. Date o	f Injury n, Day Year)	28b. Time o	f 28	c. Injury Work			28d. Describe I	now injury	occurred	
Ö	Attending in death. ector: After by the funer	atic	2 ☐ Accident invest	igation	,, ,	,,	М		res 2 🗆 l	No				
Division	al or Attence after death after death Director:	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 288. Place	of Injury - At ho ig, etc. <i>(Specif</i>)		reet, factory,	office			28f. Location (3 City or Tox		Number or R	lural Route Number,
	urs at urs at sral D													
	e Hospital or 124 hours afte e Funaral Dire tetely filled in t	edical	29a. Certifier 1 Medica:	ng Physician: To the I Examiner: On the ba and mann	sis of examinat	wedge deat tion and/or in	restigation, i	in my op	oinion, deal	th occurr	ed at the time,	date and p	lace, and du	e to the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certific		J. 010100.		29c.	License	number			29d. Date	signed (Mon	th, Day, Year)
	,L		▶ Wilkin	man J	· Ni	nala	2	D	45	2	25	Ma	rch	20,2006
	7		3. Na e and address of person	completed cause	of death (Item	23a) (Type,	Print)		17 11	3		_	0.0	20,2006
			NJ-Nin	Ja, 31	14 6	mVe	2VH	· 1	Wd	H	mell	3, 2	Ji live	2 spung, med
	Sta		31. Date filed (Month, Day, Year		gistrar's Signa	ture	ale)		/		,		
7.	Registr	ar	MAK Z	1 2006	Seco 1	A Par	ea a very							

			1 - For State Registrar	State of M	laryland		artmen rtificate					Reg. No.	6	10572
	Physici /Medio	al	EMORY C. ELBURN MARCH 19, 2006 Year 00:12 A										3. Time of Death	
	Examir Funeral	ier	4a. Facility Name (If not institution, give street and number) CHESTER RIVER HOSPITAL CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. In				CHESTERTOWN					KENT 9. Birtholace (State or Foreign		
	Director		220-28-1361 13 Usual Residence of Decedent 10a. State 10b. County	Д М 2□F	70			Days	Hours	Min. J	ULY 6°	1935		10d. Inside City Limits
2121	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	Funeral Director	MD KENT 10e. Street and Number 21749 TO LCHESTE 11. Marital Status		ROAD	ERTOWN 10f. Zip Code 21620 Was Decedent of Hispanic Origin? (Sp. 1 Yes, specify Cuban, Mexican, Puerto			jin? (Spec		USA	14. Race - American Indian,		
		To Be Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grad	1 ☐ Yes 2 X If Yes, Give Year or Dates:	1 Yes, 2 No If Yes, Give Year or Dates: ation (Give		1 ☐ Yes 2 ☑ No Specify: dent's Usual Occupation kind of work done during most of work. DO NOT use retired					Specify: WHITE 16b. Kind of Business/Industry		
			Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) GEORGE CLEVLELAN		College (1-4or 5+) MAST			ER ELECTRICIAN 18. Mother's Nat			ELECTRIC. e (First, Middle, Maiden Surname) V CANNON			
, Maryland										, PO	oral Route Number, City or Town, State, Zip Code) ORT DEPOSIT, MD 21904			
Baltimore,			20a. Method of Disposition 1								20c. Location - City or Town, State 06 ROCK HALL, MD			
	Physician /Medical Examiner	iner	FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. F. rt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Approximate interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of):											
, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	y Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	C								Day Year		
al Records,		Completed										topsy findings available completion of cause of		
sion of Vital		ation; To Be	27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpat	Other			rsing Hom	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			tify)		
Division		al Certification;	3 Suicide 6 Could not be determined									vn, State) cause(s) and		
)	To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis and manner s	of examination stated.	n and/or in	vestigation 290	in my og	oinion, deal	th occurre	d at the time,	date and pla 29d. Date si	igned (Month	to the cause(s)
D)	≻ ≤ Sta Regist		30. Name and address of person who of JAM 65 to LAC 6 31. Date filed (Month, Day, Year)	32. Regis	death (Item 2	WAS	Print)	676	DN /	evo.	crest	Bire	ww.	MO 21622

State of Maryland / Department of Health and Mental Hygiene Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 03 2006 SAMUEL FRAZIER 5:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9917 WILLIAMSBURG DRIVE UPPER MARLBORO PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 07/22/1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months XXM 2□F 72 VIRGINIA 579-42-0069 Yrs. Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be nutified at MD PRINCE GEORGES UPPER MARLBORO 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9917 WILLIAMSBURG DRIVE 20772 USA Items 23g Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) Elementary/Secondary (0-12) SALESMAN/COUNSELOR PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental i CHARLES RHODES FRAZIER ANNA MIDDOUGH ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I FRANCES L. FRAZIER/WIFE 9917 WILLIAMSBURG DR. UPPER MARLBORO, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. XXBurial 2 Cremation 3 Removal from State WASHINGTON NATIONAL 3/18/2006 SUITLAND, MD `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD 20746 Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYELOGENOUS LEUKEMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed? 1 Yes 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner Other: 4 Nursing Home XXResidence 6 Other (Specify) 2 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification; 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or, Attending Injury 1XXVatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident ector: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide afte 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D16619 03/15/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VERGARA-SOARES 8200 PROFESSIONAL PL. #1104 LANDOVER, MD 20785 31. Date filed (Month, Day, Year) MAR 2 1 2006 Registrar

DHMH 17 Rev 1/2001

	1 - State Registrar		Certificate of Deatl	and Mental Hy	Reg. No.	105/5
	Decedent's Name (First, Middle, Last	")		2. Date of De Month	Day Year	3. Time of Death
sician edical	Cornler	Ferguson		March	10 200	6 4:00 p
miner	4a. Fecility Name (If not institution, give		4b. City, Town, or Location	of Death	4c. County of Deer	
	Anne Arundel Med		Annapolis	or 24 Hrs. 8. Date of Bir	Anne Arı	
ral tor	5. Social Security Number 6. Se 350–14–3063	7. Age (In yrs. last b	Yrs. Months Days Hours		1917 Wis	thplace (State or Foreig ountry) sconsin
	10a. State 10b. County	10c. City, To	wn or Location			10d. Inside City Limit
ğ	MD Anne Ar	undel Crof	ton			1 ☐ Yes 2 XX
Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	ountry?
		dge Turn	21114		USA	
once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic			
Completed		ucation 16 completed)	a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	ost of working	16b. Kind of Business	/Industry
E E	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemaker		Own Home	
O	17. Father's Name (First, Middle, Last)		18. Mot	her's Name (First, Middle	, Maiden Sumame)	
To B			Ann	a H. Peters		
"	19a. Informant's Name/Relationship (T	ype, Print) 19	b. Mailing Address (Street and Num	ber or Rural Route Numb	er, City or Town, State, 2	Zip Code)
	Anna D. O'Kelly	(Daughter)	1411 Knights Brid	ge Turn, Cr	ofton, MD 2	1114
	20a. Method of Disposition	comot	of Disposition (Name of ery, crematory or other place)	Date	20c. Location - City or	Town, State
	1 X Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify		Lawn	3-25-2006	Bethalto,	IL
ODCO	21. Signature of Funeral Service License	fn-	22. Name and Address of Fac Hardesty Fun 12 Ridgely A	eral Home,	P.A.	1401
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do				Approximate Interval Between
	Immediate Cause (Final	one cause on each line.	1			Onset and Deat
	disease or condition resulting in death)	aDue to (or as a consequence	Hrysmia			mintelle
r		To to (or particular)		Julie		10
ě	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence		anay		- 10 grs
Ē	Cause (Disease or injury that initiated events	c				0
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	e of):			
cai		c	9 of):			
edicai		c	e of):			
edicai		d			23d. Date of del	
edicai		d			23d. Date of del Month	livery Day Year
edicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	th 3 □Ectopic pregnancy 5 □ Other (specify)			
Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d	th 3 □Ectopic pregnancy 5 □ Other (specify)		Month obacco use contribute to	Day Year the cause of death?
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II, Other significant conditions co	d	th 3 □Ectopic pregnancy 5 □ Other (specify)		Month obacco use contribute to	Day Year the cause of death?
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II, Other significant conditions co	d	th 3 □Ectopic pregnancy 5 □ Other (specify)	1 🗆 24a. Was	obacco use contribute to Yes 2 ☑No 3 ☐ Pr	Day Year the cause of death? robably 4 Unknot
ompleted by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown Part II. Other significant conditions co	d	th 3 □Ectopic pregnancy 5 □ Other (specify)	1 24a. Was	obacco use contribute to Yes 2 No 3 Pr an 24b. Were at prior to death?	Day Year the cause of death? robably 4 Unknot
e Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions co	d	th 3 □Ectopic pregnancy 5 □ Other (specify) t in the underlying cause given in Par	1 ☐ 24a. Was auto perfo	Month obacco use contribute to Yes 2 ☑ No 3 ☐ Pr an 24b. Were at prior to death? 2 ☑ No 1 ☐ Yes	Day Year the cause of death? robably 4 Unknow utopsy findings availal completion of cause of
o Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	th 3 Ectopic pregnancy 5 Other (specify) t in the underlying cause given in Par	1 □ 24a. Was auto perfc 1 □ Yes	Month Obacco use contribute to Yes 2 No 3 Pr an 24b. Were au prior to death? 1 Yes one)	Day Year the cause of death? robably 4 Unknow utopsy findings availal completion of cause of
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	th 3 Ectopic pregnancy 5 Other (specify) t in the underlying cause given in Par	24a. Was autor perficult of the control of the cont	Month Obacco use contribute to Yes 2 No 3 Pr an 24b. Were au prior to death? 1 Yes one)	Day Year the cause of death? robably 4 Unknot utopsy findings availal completion of cause of
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	th 3 Ectopic pregnancy 5 Other (specify) y in the underlying cause given in Par 26. Pla Dutpatient 3 DOA Time of 28c. Injury at	24a. Was autopento	Month obacco use contribute to Yes 2 No 3 Pr an psy 24b. Were at prior to death? 1 Yes one) dence 6 Other (Spe	Day Year the cause of death? robably 4 Unknow utopsy findings availal completion of cause of
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	th 3 Dectopic pregnancy 5 Other (specify) In the underlying cause given in Par 26. Pla Dutpatient 3 DOA Time of Injury M 1 Yes 2 [24a. Was auto performed to performe the performed to performed to performe the performance that the performanc	Month obacco use contribute to Yes 2 No 3 Pr an 24b. Were at prior to death? 2 No 1 Yes one) dence 6 Other (Spechow injury occurred	Day Year the cause of death? robably 4 Unknov utopsy findings availal completion of cause of
o Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	th 3 Dectopic pregnancy 5 Other (specify) In the underlying cause given in Par 26. Pla Dutpatient 3 DOA Time of Injury M 1 Yes 2 [24a. Was autoperforment of the control of the contr	Month obacco use contribute to Yes 2 No 3 Pr an 24b. Were at prior to death? 2 No 1 Yes one) dence 6 Other (Spechow injury occurred	Day Year the cause of death? robably 4 Unknov utopsy findings availate completion of cause
Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	th 3 Dectopic pregnancy 5 Other (specify) In the underlying cause given in Par 26. Pla Dutpatient 3 DOA Time of Injury M 1 Yes 2 [24a. Was auto perfc 1 Yes ce of Death (Check only of Nursing Home 5 Resi 28d. Describe No 28f. Location (City or Toland place, and due to the	Month obacco use contribute to Yes 2 No 3 Pr an prior to death? 1 Yes one) dence 6 Other (Spe how injury occurred Street and Number or River, State)	Day Year to the cause of death? robably 4 Unknow utopsy findings availat completion of cause of cify) ural Route Number,
To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d	th 3 Ectopic pregnancy 5 Other (specify) I in the underlying cause given in Par 26. Pla Outpatient 3 DOA Other: 4 Time of Injury M 1 Yes 2 (farm, street, factory, office	24a. Was auto performed to the path occurred at the time.	Month obacco use contribute to Yes 2 No 3 Pr an prior to death? 1 Yes one) dence 6 Other (Spe how injury occurred Street and Number or River, State)	Day Year the cause of death? robably 4 Unknow utopsy findings availate completion of cause of cify) ural Route Number, s stated, to to the cause(s)
Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown Part II. Other significant conditions condi	d	th 3 Ectopic pregnancy 5 Other (specify) g in the underlying cause given in Par 26. Pla Outpatient 3 DOA Other: 4 1 Time of Injury M 1 Yes 2 [farm, street, factory, office ge, death occurred at the time, date and/or investigation, in my opinion, de	24a. Was auto perfect of Death (Check only of Check only only only only only only only only	Month obacco use contribute to Yes 2 No 3 Propriet to death? 22 No 1 Yes one) dence 6 Other (Spectrate) bown, State) cause(s) and manner as date and place, and due 29d. Date signed (Mont)	Day Year the cause of death? robably 4 Unknov utopsy findings availat completion of cause of cify) ural Route Number, s stated, to to the cause(s)
on: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown Part II. Other significant conditions condi	d	th 3 Ectopic pregnancy 5 Other (specify) g in the underlying cause given in Par 26. Pla Outpatient 3 DOA Other: 4 1 Time of Injury M 1 Yes 2 [farm, street, factory, office ge, death occurred at the time, date and/or investigation, in my opinion, de	24a. Was auto perfect of Death (Check only of Check only only only only only only only only	Month obacco use contribute to Yes 2 No 3 Propriet to death? 22 No 1 Yes one) dence 6 Other (Spectrate) bown, State) cause(s) and manner as date and place, and due 29d. Date signed (Mont)	Day Year the cause of death? robably 4 Unknow utopsy findings availate completion of cause of cify) ural Route Number, s stated, to the cause(s)
Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 Yes 2 No 9 Unknown Part II. Other significant conditions condi	23c. If yes, outcome of pregnancy 1	th 3 Ectopic pregnancy 5 Other (specify) g in the underlying cause given in Par 26. Pla Outpatient 3 DOA Other: 4 1 Time of Injury M 1 Yes 2 [farm, street, factory, office ge, death occurred at the time, date and/or investigation, in my opinion, december 29c. License number	24a. Was auto perfect of Death (Check only of Check only only only only only only only only	Month obacco use contribute to Yes 2 No 3 Propriet to death? 22 No 1 Yes one) dence 6 Other (Spectrate) bown, State) cause(s) and manner as date and place, and due 29d. Date signed (Mont)	Day Year to the cause of death? robably 4 Unknow utopsy findings availal completion of cause of cify) ural Route Number, s stated, to the cause(s)

				State of			artment of F				giene	0 0 0	a Com and to
		1	For State Registrar				rtificate of				Reg. No.	UUb	10076
25	Dhysisi	4.3	1. Decedent's Name (First, Midd							2. Date of De Month	Day	Yea	3. Time of Death
	Physicia /Medic	al -	William Lee				4b. City, Town, o	r Logation	of Doath	03	15	200 county of De	
	Examin	er	4a. Facility Name (If not institution Carroll Hos				Westmin					rrol	
	Funeral	.48	5. Social Security Number	6. Sex		. last birthday)				8. Date of Bir	é la	0.0	irthplace (State or Foreign Country)
di di	Director	2	214-34-4208	1 M 2 □ F	69	Yrs.	Months Days	riodis	141111.	12/31	/193	36 M	arýland
	and w	. ⊢	Usual Residence of Decedent 10a. State 10b. Count	у	10c. C	city, Town or Lo	ocation						10d. Inside City Limits
	Maryll ied	ō	MD Cari	coll	На	mpstea	ad						1 ☐ Yes 3 No
	r 28a	Directo	10e. Street and Number				10f. Zip Code				10g. Citize	en of What	Country?
	th wit	ai D	4903 Miller				21074				ŲS		
	tems	Funerai	11. Marital Status	Armed F		U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Or an, Mexicai	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	D- 1	4. Race - Ar Black, W	nerican Indian, hite, etc.
36	rs afte	by F	1 Never Married 2X Ma 3 Widowed 4 Divorce		2□No ive Dates:1954	-73	1 ☐ Yes 2 ☑ No	Specify:	:		3	Specify:	white
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. other then "natural; or items 23s or 28s-f ehow ent, I'm Medical Evanti et must be notified at	ted	15. Decede	nt's Education		16a, Dece	edent's Usual Occup kind of work done	pation	st of work	ing	16b. Kin	d of Busines	ss/Industry
215	thin 7 en "n	Completed	Elementary/Secondary (0-12)	est grade completed College	/ (1-4or 5+)	life.	DO NOT use retire	d)		9			
21	led wi		12	(act)		Sec	curity (e (First, Middle		ecur	ıty
and	ould be fi Mental H arked ott	Be	17. Father's Name (First, Middle Loy Kermit							e Cece			S
7	should and Men s marks umatic	ပ္	19a. Informant's Name/Relation			19b. Mail	ing Address (Street	and Numb	er or Rur	al Route Numb	er, City or	Town, State	a. Zip Code) 21074
	and 2 salth a n 27 is		Mary Jane 1	Trye, Wit		w .	3 Mille					-	
ore	of He of He If item	1	20a. Method of Disposition 1 □ Burial 2 □ Cremation	n 3 □Removal fron	20b.	Place of Disp cemetery, cre	osition (Name of ematory or other pla			Date			or Town, State
Baltimore,	Pages tment of I tant: If it		4 ☐Donation 5 ☐ Other	(Specify)	Ne		heran C						ster, MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23a or 28a-f show any injury or other traumatic event, II a Medical Examinet must be notified at Once.		21. Signature of Funeral Service	2 /auli	MOO		2. Name and Addr 934 S. 1						
			23a. Part1. Enter the disease,	or complications that	caused the de							Jecuu	Approximate Interval Between
	Physician		shock, or heart failure. Li Immediate Cause (Final disease or condition	st only one cause on	OPT								Onset and Death
18	/Medical		resulting in death)	a	o (or as a conse	equence of):							
63,	Examiner		Sequentially list conditions,	b	o (or as a conse	navaraa af):							
	ped nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹ 500 11	O (OI as a COIIse	equence on.							
Ć,	be executed ician and buriat-transit	Examiner	that initiated events resulting in death) Last	c	o (or as a cons	equence of):							
760,	o ys	cai		d									
68 ×	death certifica e attending ph ed for use as th	Physician/Medi	IF FEMALE:	225 16 1100	utaama at scaa							2d Data of	dalivani
Вох	ath ce attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of preg birth 2 TFe gnant at time of	etal death 3	☐Ectopic pregnand	су			2	3d. Date of Month	Day Year
P.O.	0 0	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unk			E othor (openly)						
	res that signed b be deta	by P	Part II. Other significant cond	itions contributing to	death but not r	esulting in the	underlying cause g	ven in Part	I.	23e. Did	tobacco us		e to the cause of death?
ıdş	w require been sig should b	ed t	HTN							7	Yes 2]No 3[Probably 4 Unknown
ecc	a Sici	Completed	CAD							24a. Wa aut	s an opsy formed?	24b. Were prior death	autopsy findings available to completion of cause of
<u>س</u>			DM							1 Yes	2 00	1 🗆 `	
ξ	Physician: The this certificate ral director, pag	Be	25. Was case referred to medi examiner? 1 Yes 25 No	Hospital:	Inpatient 2	☐ ER/Outpatio	ent 3 DOA O	hor		th (Check only ome 5 ☐ Res		COther (5	Specify)
o	<u>_</u> = _a	n: To	27. Manner of Death	28a. Dai	e of Injury	28b. Time	of 28c. Inju		tursing r	28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ion	Attending r death. ector: After by the fune	atio	E	stigation		injury		Yes 2]No				
Division of Vital Records,	or Atterde	Certification:			ce of Injury - Al Iding, etc. <i>(Sp</i> e		street, factory, office	•			(Street and own, State)		r Rural Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a, Certifier Certif	ying Physician: To t	he best of my l	nowledge, dea	ath occurred at the	time, date a	and place	, and due to th	e cause(s)	and manne	r as stated.
	Ne Hos	Medicai	(Check only 2 Medic one)	al Examinar: On the	basis of exam anner stated.	ination and/or	investigation, in my	opinion, de	ath occu	rred at the time	e, date and	place, and	due to the cause(s)
	To the I within 2 To the I complet	×	29b. Signature and title of cert	fier				nse number				1	onth, Day, Year)
	WIL			mode	_ iN	D	Doc	0610	45	anda ~	-	3/17/	06
	6		30. Name and address of pers	1	use of death (I	tem 23a) (Type	December Print) M.	d D	211	57	· D.		
*	St	ate	31. Date filed (Month, Day, Ye	ar) 32	Registrar's Sig	gnature	,	-					
2	Regist		MAR	1 7 2006	House	, SK	Coole						
-	15.41 1 47 0- 44	0001					7						

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. U U D Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 2006 рм **Physician** Dorothy Μ. Foster March ĭ9, 1:24 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery General Hospital 01nev If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,)
July 12, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6 Sax 5. Social Security Number ^{Yea}r) 1923 **Funeral** Days Hours Washington, DC 1□M 21 F July 82 Yrs 578-20-9469 Director Usual Residence of Decedent 10d. Inside City Limits Manyland 10b. County 10c. City, Town or Location 10a State 28a-f show troumatic event, the Medical Examiner must be notified at 1 ☐ Yes X ☐ No Director Montgomery Silver Spring Maryland the ! 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 20906 3525 S. Leisure World Blvd. itame 23a Pages 1 and 2 should be filed within 72 hours after death 1 nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or flame 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify White 3 -Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Labor Union Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Catherine Osterman Claude Bailey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6009 89th Avenue, New Carrollton, MD 20784 Kathleen Andrews/ Niece other 1 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Depertment of H Important: If ite any injury or of once. cemetery, crematory or other place) March 21 1 ☐ Burial 2 【③Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 2006 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 Days Immediate Cause (Final Cerebral Hemorrhage Privsician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 Years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. I ed by the a detached f 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No 2 🔀 No 1 Yes certificate Division of Vital or Attending Physicien: After this certification funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation 2 Accident To the Hospitel or Attend within 24 hours after death To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contribut March 19, 2006 D26540 he 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 16220 Frederick Road, Gaithersburg, MD 20877 Schoenberger, Carl I. 31. Date filed (Month, Day, Year)
MAR 2 2 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Guy 16, Fleegle March 20.06 6:20 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Devlin Manor Health Care Center Cumberland Allegany Birthplece (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1∭ M 2□ F Director 212-24-0558 02/16/1928 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "..... 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 TYes 2 □ No Cumberland Director Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 135 N. Mechanic Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No 1950-1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify: Specify. þ 1956 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Security Guard U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Burton Fleegle Hazel Dawson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patty L. Fleegle / wife 135 N. Mechanic Street, Cumberland, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation 5 □ Other (Specify) Restlawn Mem. Gardens 03/20/2006 LaVale, Maryland 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Foneral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SUDDEN disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dive to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown n signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 No 1 ☐ Yes 2 ☑ No 1 Yes or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Marsing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA funeral 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 -Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide **MCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054004 Larzan March 16, 2006 UP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) مود Shiv C. Khanna, M.D., 1221 National Highway, LaVale, Maryland 31. Date filed (Month, Day, Year) 7 2006 32. Resistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Amended #26, nls, 03/17/06, Allegany Co

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-	O	1000	0	1
	U	7	Ö	L

			For State Registrar				C	ertificat	e of	Death			Reg. No.	A 1007 300	10,	
			1. Decedent's Nam	ne (First, Middle,	Last)							2. Date of De		and Year		ne of Death
	Physici /Medio		Ruth M.	Fatkin								Ma		, 2006 ^{ar}	09:45	AM
	Examir		4a. Facility Name (-			4b. City,		Frostb				County of Dea legany	ith	
			12729 Va 5. Social Security I		t Road, SW		In yrs. last birthd	lf Unde	r 1 Year	If Under		8 Date of Bi			tholace (St	ate or Forei
Ŀ	Funeral Director		215-16-45	1	1 □ M 2 TOF	7. Age (1		Months		Hours	Min.	8. Date of Bi Month, D 26-Sep	1921	We	st"Virg	inia
	pu 🛦		Usual Residence of	of Decedent 10b. County		1	Oc. City, Town o	r Location							10d, Insid	de City Limit
	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show lised Examination in the Indifficed at	tor	Maryland	Alle	gany		Frostburg	. 2004.011								Yes 2V
	or 28e	Director	10e. Street and Nu	umber 12729	Vale Summ	it Road	d, SW		Code				_	en of What C	ountry?	
	ath w	- a			12.111. 5				532-		i=i=2 /C=	naifu Van ar N	U.S.A	4. Race - Am	orioan India	
	er de Items	Funeral	11. Marital Status	wind OCT Mossia	12. Was Dec	orces	er in U.S.	If Yes, spe	cify Cuba	an, Mexica	n, Puerto	ecify Yes or N Rican, etc.)		Black, Whi	ite, etc.	211,
220	el', or	þ		ried 2 Marrie 4 Divorced	If Yes, Gi Year or E	2XINo ive Dates:		1 🗌 Yes	21X (No	Specify	:		S	Specify. Wh	ite	
<u> </u>	_ 2 10	Completed	(Spe	15. Decedent's ecify only highest	Education grade completed))	16a. Do	ecedent's Usu Give kind of wo fe. DO NOT u	al Occup ork done	ation during mos	st of work	ing	16b. Kind	d of Business	s/Industry	
Maryland 21215-0036	withir and the the	omp	Elementary/Sec	condary (0-12)	College ((1-4or 5+)		isekeepii					nursi	ing facil	ity	
פ	a filed al Hygie other vent, II	BeC	17. Father's Name	(First, Middle, L	ast)							e (First, Middle		Sumame)		
	2 should be and Mental Is marked of sumatic even	70	Robert I	Radcliff								e Zembo				
Mar	s 1 and 2 should f Health and Men item 27 is marke other treumatic		19a. Informant's N		ip (Type, Print) SON	1	127	29 Vale S	Summ	it		al Route Numi stburg		aryland		.532
			20a. Method of Dis	sposition	_		20b. Place of Constery,	isposition (Na crematory or	me of other pla	ce)		Date		ation - City o		
saitimore,	Page ent c nt: If ry or			2 ☐ Cremation 5 ☐ Other (Sp.	3 □Removal from ecify)	State	Vale Sum				18-	Мат-2006	Vale Si	ummit]	Marylar	ıd
Dail	permit. Pa Departmer Important any injury		21. Signature of F	uneral Service L	Dur	1		22. Name a Durst	nd Addre	ess of Facil	ity 1e, 57 I	Frost Ave	Frostb	ourg, MD	21532	
	Physician /Medical Examiner		23a. Part 1. Enter shock, or he Immediate Cause disease or condit resulting in death	(Final	a Due to	11	ne death. Do not	enter the mo						R	Approx Interva Onset	ximate al Between and Death
	/Medical Examiner	Ical Examiner	Immediate Cause disease or condit	o (Final ion) conditions, imm to derlying or injury its	a	o (or as a o	MK	enter the mo						2	Approx Interva Onset	ximate al Between and Death
. Box 68760,	/Medical Examiner	edical	Immediate Cause disease or condit resulting in death Sequentially list of any leading cause. Enter Unc Cause (Disease of that initiated even	e (Final ion) conditions, introduction in injury its) Last ent pregnant 2 months?	a	o (or as a of o (or a))))))))))))))))))))))))))))))))))))	consequence of)	enter the mo	de of dyin	ng, such as			arrest,	3d. Date of do	Onset	ximate al Between and Death Year
P.O. Box 68760,	/Medical Examiner	edical	Immediate Cause disease or condition resulting in death resulting in death sequentially list of any leading cause. Enter Unic Cause (Disease of that initiated even resulting in death, limitiated even for the past 1 1 2 Yes 2 9 1 Unknown	conditions, and the deriving or injury its) Last	a	o (or as a o o (or as a o o (or as a o o o (or as a o o o (or as a o o o o o o o o o o o o o o o o o	consequence of) consequence of) consequence of) pregnancy Fetal death me of death	enter the mo	oregnanc	ng, such a	s cardiac	or respiratory	arrest,	3d. Date of di	Onset	Year
P.O. Box 68760,	/Medical Examiner	edical	Immediate Cause disease or condition resulting in death resulting in death sequentially list of any leading cause. Enter Unic Cause (Disease of that initiated even resulting in death, limitiated even for the past 1 1 2 Yes 2 9 1 Unknown	conditions, and the deriving or injury its) Last	a	o (or as a o o (or as a o o (or as a o o o (or as a o o o (or as a o o o o o o o o o o o o o o o o o	consequence of) consequence of) consequence of) pregnancy Fetal death me of death	enter the mo	oregnanc	ng, such a	s cardiac	23a. Did	arrest,	3d. Date of di Month	Onset	Year
P.O. Box 68760,	raw requires that the death certificate be exacuted as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical	Immediate Cause disease or condition resulting in death resulting in death sequentially list of any leading cause. Enter Unic Cause (Disease of that initiated even resulting in death, limitiated even for the past 1 1 2 Yes 2 9 1 Unknown	conditions, and the deriving or injury its) Last	a	o (or as a o o (or as a o o (or as a o o o (or as a o o o (or as a o o o o o o o o o o o o o o o o o	consequence of) consequence of) consequence of) pregnancy Fetal death me of death	enter the mo	oregnanc	ng, such a	s cardiac	23e. Did	arrest, 23 tobacco us Yes 2 s an opsy	3d. Date of di Month se contribute No 3 F	Onset elivery Day to the caus Probably autopsy fince o completion	Year e of death?
P.O. Box 68760,	Tha law requires that the death certificate be exacuted as the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	Immediate Cause disease or condition resulting in death resulting in death sequentially list of any leading cause. Enter Unic Cause (Disease of that initiated even resulting in death, limitiated even for the past 1 1 2 Yes 2 9 1 Unknown	conditions, and the deriving or injury its) Last	a	o (or as a o o (or as a o o (or as a o o o (or as a o o o (or as a o o o o o o o o o o o o o o o o o	consequence of) consequence of) consequence of) pregnancy Fetal death me of death	enter the mo	oregnanc	ng, such a	s cardiac	23e. Did	tobacco us Yes 2 s an opsy	3d. Date of di Month se contribute No 3 F	elivery Day to the caus Probably autopsy finc	Year e of death? 4 Unknow
P.O. Box 68760,	Tha law requires that the death certificate be exacuted as the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Immediate Cause disease or condition resulting in death resulting in death Sequentially list of cause. Enter Unc Cause (Disease of that initiated even resulting in death, 1	conditions, in the bertying or injury or injur	a. Due to b. Due to c. Due to d	o (or as a o o (or as a o o (or as a o o o (or as a o o o (or as a o o o o o o o o o o o o o o o o o	consequence of) consequence of) consequence of) pregnancy Fetal death me of death not resulting in the	a enter the mo	oregnance pecify)	y ven in Part	I.	23e. Did 1 1 24a. Wa aut 1 1 Yes	tobacco us Yes 2 s an opsy formed? 2(7) No	3d. Date of do Month se contribute No 3 F	elivery Day to the caus Probably autopsy find o completion os 2 \(\) No	Year e of death? 4 Unknow
Vital Records, P.O. Box 68760,	Physicien: The law requires that the death certificate be executed to the certificate has been signed by the attending physician and aldirector, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause disease or condit resulting in death Sequentially list of cause. Enter Unc Cause (Disease of that initiated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1	conditions, in the deriving or injury its sat sent pregnant 2 months? In No inflicant condition in the deriving of injury its sat sent pregnant 2 months?	a	o (or as a o o o (or as a o o o o o o o o o o o o o o o o o	consequence of) consequence of) consequence of) pregnancy Fetal death me of death not resulting in the	atient 3 D	oregnanc pecify)	y ven in Part	I.	23e. Did	tobacco us Yes 2 s an opsy formed? 22 No rone) sidence 6	3d. Date of di Month se contribute No 3 F	elivery Day to the caus Probably autopsy find o completion os 2 \(\) No	Year e of death? 4 Unknow
of Vital Records, P.O. Box 68760,	sing Physicien: The law requires that the death certificate be executed by the attending physician and before this certificate has been signed by the attending physician and before the burial-transit and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Causs disease or condit resulting in death Sequentially list of any landing to the cause. Enter Unc Cause (Disease of that intitated even resulting in death) IF FEMALE: 23b. Was deceded in the past 1 1 2 4 2 2 9 1 2 2 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3	ent pregnant 2 months? No mifficant condition erred to medical	a	o (or as a o o (or as a o o (or as a o o o (or as a o o o o o o o o o o o o o o o o o	consequence of) consequence of) consequence of) pregnancy Fetal death me of death not resulting in the	atient 3 D	oregnance pecify) cause gn OA Otto	y ven in Part	I.	23e. Did 1 24a. Wa per 1 Yes h (Check only)	tobacco us Yes 2 s an opsy formed? 22 No rone) sidence 6	3d. Date of di Month se contribute No 3 F	elivery Day to the caus Probably autopsy find o completion os 2 \(\) No	Year e of death? 4 Unknow
of Vital Records, P.O. Box 68760,	sing Physicien: The law requires that the death certificate be executed by the attending physician and before this certificate has been signed by the attending physician and before the burial-transit and funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Immediate Cause disease or condit resulting in death Sequentially list of any leading to the cause. Enter Unc Cause (Disease of that intitated even resulting in death) IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknown Part II Other sign 25. Was case reference of the cause	erred to medical No ath 5 Pending investig 6 Could n	a. Due to b. Due to c. Due to d	utcome of birth 2 ynant at timenown death but	consequence of) consequence of	atient 3 De Dine of	oregnance pecify)cause gn	y ven in Part	I.	23e. Did 24a. Wa per 1 Yes 28f. Location	tobacco us Yes 2 s an opsylormed? 22 No one) sidence 6 how injury	3d. Date of di Month se contribute No 3 F 24b. Were a prior to death? 1 Ye Cocurred	elivery Day to the caus Probably autopsy find p completion as 2 \(\subseteq \) No	Year e of death? 4 Munknov
of Vital Records, P.O. Box 68760,	sing Physicien: The law requires that the death certificate be executed by the attending physician and before this certificate has been signed by the attending physician and before the burial-transit and funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Immediate Cause disease or condit resulting in death Sequentially list of cause. Enter Unc Cause (Disease of that initiated even resulting in death, IF FEMALE: 23b. Was deceded in the past 1 1	erred to medical No ath Someticant conditions and pregnant 2 months? Continue And And And And And And And An	a. Due to b. Due to c. Due to d	o (or as a of or as a	consequence of) consequence of) consequence of) consequence of) pregnancy Fetal death me of death not resulting in the consequence of) 28b. Tin Injury Year) 28b. Tin Injury Year) wy - At home, farm (Specify)	atient 3 Death occurrent	oregnance pecify)	y ven in Part 26. Plac her: ry at rk? Yes 2 [I	23e. Did 1 24a. Whaut 24a. Whaut 25 Accepted to the confusion of the conf	arrest, 23 I tobacco us Yes 2 s an opsy formed? 22 No rone) sidence 6 e how injury (Street and own, State) e cause(s) a	3d. Date of do Month se contribute No 3 F 24b. Were a prior to death? 1 Yes GOOther (Sp	elivery Day to the caus Probably autopsy find o completion as 2 \(\subseteq \) Rural Route as stated.	Year e of death? 4 Munknow dings availate of cause of
.0. Box 68760,	or Attending Physicien: The law requires that the death certificate be executed the death. Solution of the continuation of th	To Be Completed by Physician/Medical	Immediate Cause disease or condit resulting in death Sequentially list of any leading to the past of that initiated even resulting in death. IF FEMALE: 23b. Was decede in the past of t	erred to medical No ath For Pending investig Governing Certifying Certifying Medical E	a. Due to b. Due to c. Due to d	utcome of birth 2 phant at time of Injury onth, Day 1	consequence of) consequence of) consequence of) consequence of) pregnancy Fetal death me of death not resulting in the consequence of) 28b. Tin Injury Year) 28b. Tin Injury Year) wy - At home, farm (Specify)	atient 3 D atient 3 D atient 3 D me of any M n, street, factor investigation	oregnance pecify)	y ven in Part 26. Plac her: ry at rk? Yes 2 [I	23e. Did 1 24a. Whaut 24a. Whaut 25 Accepted to the confusion of the conf	tobacco us Yes 2 s an opsy formed? 22 No cone) sidence 6 e how injury (Street and own, State) e cause(s) a a, date and	3d. Date of do Month se contribute No 3 F 24b. Were a prior to death? 1 Yes GOOther (Sp	elivery Day to the caus Probably autopsy finc completion as 2 No	Year e of death? 4 Munknow dings availat n of cause of

State

31. Date filed (Month, Pay, Year), 2006

32. Fegistrar's Signature

30. Name and address of person yets complete the same of death stem 232. (Type Print) and, Maryland 21502

D13601

March 16, 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** March 20, 2006 12:30 P.M Paul Edward Fazenbaker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Egle Nursing Home Lonaconing If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months August 21, 1940 Maryland 215-42-4566 65 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Lonaconing Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 16918 Blueberry Lane 21539 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0020 Specify: Specify: Š 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver 10 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othens Catherine Brennan Robert Lee Fazenbaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16918 Blueberry Lane, Lonaconing, Maryland, 21539 Peggy Fazenbaker - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 23, 1 ■ Burial 2 □ Cremation 3 □ Removal from State Frostburg, Maryland Frostburg Memorial Park 2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee E Miller 8 East Main St., Lonaconing, MD 21539 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** days Immediate Cause (Final disease or condition resulting in death) /Medical Diemonia Examiner Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral INFARCT with Right Remip. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes Cerman 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mrt roh 22, 2006 D 25638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SATURNIANA CHANG M.D. 4 BROAD Way Frustlewy Maryland 21532 31. Date filed (Month, Day, Year) 32. Registrár's Signature State 2006 Registrar

					Certific	ate of	Death	2. Date of De	Reg. No.	JU IU
sician	1. [ecedent's Name (First, Middle,						Month	Day	Year 3. Tim
ledical	40	Facility Name (If not institution,		wmborl		ray	4b. City, Town, or	Location of Deat	h 4c. County	of Death
aminer	48	HCR-Ma					Adels	olai	0	Georges
eral	5. S		S. Sex	7. Age (In yrs.		der 1 Year		8. Date of Bi	rth	9. Birthplace (Sta Country)
tor		15-16-5036	1₫M 2□F	86	Yrs. Mont	ns Days	Hours Min	8. Date of Bi (Month, Di Nov . 1	9, 1919	Macon, G
Director	-	al Residence of Decedent . State 10b. County		10c. Cit	y, Town or Location					10d. Insid
ŏ		DC		Wa	shington					1迄
<u>1</u>	10e	. Street and Number			10f.	Zip Code			10g. Citizen of	What Country?
Funeral Director	5	09 Kennedy Str	eet NW			200			USA	
ner.	1	Marital Status	Armed		,S. 13. Was De If Yes, s	cedent of h	lispanic Origin? (S an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Rad Bla	ce - American India ck, White, etc.
by Fu		1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1X Yes	2 □ No Give			Specify:		Specif	^{fy:} Black
졌		15. Decedent's	Year or	Dates:	16a, Decedent's L	Isual Occur	pation		16b. Kind of B	Business/Industry
plet	_	(Specify only highest	grade completed		(Give kind of life. DO NO	work done T use retire	during most of wo d)	orking		
Completed	['	Hementary/Secondary (0-12)	College	(1-4or 5+)	Limo	Drive	r		Priv	ate
BeC	17.	Father's Name (First, Middle, La	ıst)						e, Maiden Sumar	me)
To		Jnknown					Unkn			·
		a. Informant's Name/Relationship								n, State, Zip Code) n , MD 2074
	-	Lara Stephens/D	aughter	20b. F	Place of Disposition (Name of		Date		- City or Town, Stat
	200	1 ☑ Burial 2 ☐ Cremation 3		_ (cemetery, crematory antico Na	or other pla	ce) 1 Ceme.		Triang	-
	21	4 Donation 5 Other (Spe Signature of Funeral Service Lit		Qu					_	ns Funera
		Soho	11	e note .			dy St. N			
	23	a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications ha	t sused the deal						Approx
n		shock, or heart failure. List or	ily one cause or	each line.						Interval Onset
al er	dis	nediate Ceuse (Final ease or condition		ardio	pulmon	ary	avve	57		
	res	ulting in death)		Due to (or as a consequence	of):	•			
aminer		4	b		stive c		omyo	pathy		
Exar	Se if e	quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or injury		Due to (or as a consequence	of):		·		
_	Cal	use (Disease or injury	c	Prest	ate co	of)·				
Ca	tha	t initiated events								į
Medical	tha	t initiated events ulting in death) Last		1 5001010	1 Can live	. C .=				
an/Medical	tha	t initiated events	d	rena	1 failu	re				
/sician/Medical	tha	t initiated events	ds contributing to			√ ℃ ng cause gi	ven in Part I.	23b. Dic	I tobacco use co	ontribute to the car
Physician/Medical	tha	t initiated events ulting in death) Last t II. Other significant conditions	ds contributing to			√ ℃	ven in Part I.		1 tobacco use co	
d by Physician/Medical	Par	t initiated events ulfing in death) Last	ds contributing to			√ €	ven in Part I.	1 = 24a. Wa	Yes 2 XNo	3 ☐ Probably 24b. Were auto
leted by Physician/Medical	Par	t initiated events ulting in death) Last t II. Other significant conditions	s contributing to			√ €	ven in Part I.	1 = 24a. Wa	Yes 2 XNo	3 ☐ Probably
ompleted by Physician/Medical	Par	t initiated events ulting in death) Last t II. Other significant conditions	ds contributing to	death but not res	sulting in the underlying		ven in Part I.	24a. Wa	Yes 2 XNo	3 Probably 24b. Were auto available p completion
Completed	Par	t initiated events ulting in death) Last t II. Other significant conditions A Per po	d. s contributing to	death but not res				24a. Wa	yes 2 XNo s an autopsy formed?	3 Probably 24b. Were auto available p completior of death?
Be Completed	Par 25.	t initiated events ulting in death) Last III. Other significant conditions Avenue	a vath	death but not res	sulting in the underlying	S DOA OIL	26. Place of Do	24a. Wa peri	s an autopsy formed?	3 Probably 24b. Were auto available p completion of death? 1 Yes
Be Completed	Par 25.	t initiated events ulting in death) Last t II. Other significant conditions A Per Po Vas custa Was case referred to medical examiner? 1 Yes 2 No Menner of Death 1 2 Natural 5 Pending	Hospital: 15	death but not res	LER/Outpatient 3C 28b. Time of Injury	DOA Otil	26. Place of Do	24a. Wa peri	s an autopsy formed?	3 Probably 24b. Were auto available p completion of death? 1 Yes
Be Completed	Par 25.	t initiated events ulting in death) Last t II. Other significant conditions A PP P Was case referred to medical examiner? 1 Yes 2 No Menner of Death 12 Accident 5 Pending investigal	Hospital: 15 28a. Dai	Inpatient 2	LER/Outpatient 3C 28b. Time of Injury	DOA Otl	26. Place of Do her: Nursing ry at rk? I Yes 2 □ No	24a. Wa peri	s an autopsy formed? Yes 2 No one) sidence 6 Ote how injury occu	3 Probably 24b. Were auto available p completior of death? 1 Yes
Be Completed	Par 25.	t initiated events ulting in death) Last t II. Other significant conditions A Per Port Was case referred to medical examiner? I yes 2 No Menner of Death Menner of Death	Hospital: 1 28a. Date of the 28e. Pla	Inpatient 2	LER/Outpatient 3C 28b. Time of Injury M	DOA Otl	26. Place of Do her: Nursing ry at rk? I Yes 2 □ No	24a. Wa peri	s an autopsy formed? Yes 2 No one) sidence 6 Ote how injury occu	3 Probably 24b. Were auto available p completion of death? 1 Yes
Be Completed	Par 25.	t initiated events ulting in death) Last t II. Other significant conditions A P P P Was case referred to medical examiner? I yes 2 No Menner of Death 1 Natural 5 Pending investiga 2 Accident 3 Suicide 6 Could no determine a. Certifier Certifying	Hospital: 1 28a. Dai (M. 28e. Pla bui	death but not res	DER/Outpatient 3 28b. Time of Injury Mome, farm, street, factory owledge, death occur	DOA OII 28c. Inju Wc 1 Ctory, office	26. Place of Doher: Nursing ry at rk? Yes 2 \sum No	24a. Wa peri 24a. Wa peri 24a. Wa peri 24a. Wa peri 24a. Ucation 25d. Describe 28f. Location City or To	s an autopsy formed? Yes 2 No sidence 6 Ote how injury occu (Street and Numown, State) e cause(s) and m	3 Probably 24b. Were auto available p completior of death? 1 Yes ther (Specify) arred aber or Rural Route
Be Completed	Par 25.	t initiated events ulting in death) Last t II. Other significant conditions A P P P Was case referred to medical examiner? I yes 2 No Menner of Death 1 Natural 5 Pending investiga 2 Accident 3 Suicide 6 Could no determine a. Certifier Certifying	Hospital: 11 28a. Dat (M) 28e. Pla buil Physician: To t texaminer: On the	death but not res	DER/Outpatient 3C 28b. Time of Injury Mome, farm, street, factor)	DOA OII 28c. Inju Wc 1 Ctory, office	26. Place of Doher: Nursing ry at rk? Yes 2 \sum No	24a. Wa peri	s an autopsy formed? Yes 2 No sidence 6 Ote how injury occu (Street and Numown, State) e cause(s) and m	3 Probably 24b. Were auto available p completior of death? 1 Yes ther (Specify) arred aber or Rural Route
Completed	Par 25.	t initiated events ulting in death) Last t II. Other significant conditions A PP PP Was case referred to medical examiner? Types PR Menner of Death 12 Accident 3 Suicide 6 Could no determine (Check only 2 Medical Examiner) a. Certifier (Check only 2 Medical Examiner) Medical Examiner (Check only 2 Medical Examiner)	Hospital: 11 28a. Dat (M) 28e. Pla buil Physician: To t texaminer: On the	Inpatient 2 Inpati	DER/Outpatient 3 28b. Time of Injury Moome, farm, street, factly) Devledge, death occuration end/or investiga	DOA Oth 28c. Inju Wo 1 ctory, office red at the tition, in my 29c. Licen	26. Place of Do her: Nursing ry at rk? I Yes 2 No ime, date and plac opinion, death occ se number	24a. Wa peri	s an autopsy formed? I Yes 2 No one) sidence 6 Ot how injury occu (Street and Num own, State) e cause(s) and me s, date and place	3 Probably 24b. Were auto available p completior of death? 1 Yes ther (Specify) arred ther or Rural Route nanner es stated. and due to the car ed (Month, Day, Ye)
Be Completed	Par 25.	t initiated events ulting in death) Last t II. Other significant conditions A PP PP Was case referred to medical examiner? I Yes 2 No Wenner of Death PRINatural 5 Pending investiga investiga of determined. Check only one) a. Certifier (Check only one) Check only one) Was case referred to medical examiner? A case of the conditions of the cond	Hospital: 11 28a. Dat (M) 28e. Pla buil Physician: To t texaminer: On the	Inpatient 2 Inpati	DER/Outpatient 3 28b. Time of Injury Mome, farm, street, factory owledge, death occur	DOA Oth 28c. Inju Wo 1 ctory, office red at the tition, in my 29c. Licen	26. Place of Doher: Nursing ry at rk? I Yes 2 No	24a. Wa peri	s an autopsy formed? I Yes 2 No one) sidence 6 Ot how injury occu (Street and Num own, State) e cause(s) and me s, date and place	3 Probably 24b. Were auto available p completior of death? 1 Yes ther (Specify) pred abor or Rural Route nanner es stated.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician March 2006 Frederick Leslie Gebhardt 1411 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Carroll Hospital Center Westminster 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) May 16 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 12XM 2□ F Yrs. 003-32-6375 61 Mass Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h County 10a State id 2 should be filed within 72 hours after death with the Maryla Ith and Mantal Hyglene. 27 is marked other than "natural", or items 23a or 28a-f sho; "traumatic event, "ta "fedical Examinas the notified as MD Carroll Westminster 1 Tyes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2256 Ridge Road 21157 USA Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No 1963 If Yes, Give 1 ☐ Never Married 2X Married 5-0036 1 Yes 2 No Specify: White Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 1966 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) College (1-4or 5+) Electronics Mechanic Giant Food 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be end 2 should be Ethel Katherine Beswick Carl Herman Gebhardt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health a Important: If item 27 is any injury or other trai 2256 Ridge Road Westminster, MD 21157 Jeris L. Gebhardt/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Carroll Cremation, Inc 3/21/2006 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. -K 412 Washington Road Westminster, MD 21157 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sophageel **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner mhyema Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a co sequence of): Examiner transit death certificate be executed and anding physicien an use as the burial-tr resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached o 9 Unknown 9 Unknown م 23e. Did tobacco_use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 1 TX Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cete has page 2 s certificete 21 No 1 Yes of Vital After this certifical funeral director, Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 In atient 2 ER/Outpatient 3 DOA ဥ 1 ☐ Yes 2 ☐ M6 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division Injury 1 Watural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03-20-66 WSL 12 ralcain dune, Westminsty MD 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NA Keineug -ecman 31. Date filed (Month, Day, Year) 32. Signature State MAR 2 1 2006 Registrar

			For State Registrar	State	of Marylan		artment of H rtificate of L			Re	g. No. U		1058	} ;
	Physicia	20	1. Decedent's Name (First, Middle	Last)					2.	Date of Death Month	n Day	Year	3. Time of D	
	/Medic	al .	Virgil Russ		ertz					arch	17,	2006	8:30	_p ^M
	Examin	er	4a. Facility Name (If not institution	give street and r	number)		4b. City, Town, or		f Death			,	***	
	Francis		Casey House 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Rockvil If Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birth (Month, Day,		tgome 1 9. Birthp	ace (State or try)	Foreign
	Funeral Director		567-09-1250	1⊠M 2□F		84 Yrs.	Months Days	Hours	Min. 1	1/17/19	921	Ores		
9	> les		Usual Residence of Decedent 10a. State 10b. County		100 Cib	y, Town or Lo	postion					10	d. Inside City	/ Limits
faryla	shov a pa	ក	7.0									,	1 X Yes	
the N	28a-f	Director	DC None 10e. Street and Number		W	ashing	10f. Zip Code			10	Og. Citizen of	What Coun	try?	
with	3a or		3700 North Ca	oital St	reet. NW		20011-	8400			Unite	d Stai	ies	
death	me 2	Funeral	11. Marital Status	12. Was De	ecedent Ever in U. Forces?	S. 13.	Was Decedent of Hi If Yes, specify Cuba		gin? (Specif	y Yes or No-	14. Ra	ce - Americ	an Indian,	
affe 6	or Its	E.	1 Never Married 2 Marri	ed 1X1Ye	s 2 ∐ No Give		1 ☐ Yes 2 ☑ No	Specify:	, , , , , , , , , , , , , , , , , , , ,	, 0.0.,				
5-0036 72 hours after death with the Maryland	tural',	d by	3 ☐ Widowed 4 ☑ Divorced		Dates: WWII	16a Dece	dent's Usual Occupa	ation			16b. Kind of E	fy: Cauca	asian	
ة 2 ك	ledical	Completed	15. Decedent (Specify only highes	t grade complete		(Give	kind of work done of DO NOT use retired	during most	of working		rop. Kind or t	703111033F1110	idatiy	
212 E	r than	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	Mas	ter Sarge	nt			U.S.	Army		
ם 📲	t other	Be C	17. Father's Name (First, Middle,	_ast)				18. Mothe	r's Name (F	irst, Middle, N	Aaiden Suma	me)		
yang bulg b	Menta arked atic e	2	Oscar Gertz						lah A					
a 2 sh	ls m		19a. Informant's Name/Relations				ng Address (Street a							
e, P	Health em 27 ther t		David Hearn / 1	riena	20b. F	Place of Dispo	Jamison osition (Name of		, Ger		Mar 20c. Location			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at	Department of Health and Mental Hygiene. Important: or Itame 23s or 28s-f show Important: If Item 27 is marked other than "natural", or Itame 23s or 28s-f show any injury or other treumatic event, the Medical Examinar must be notified at once.		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S)		m State	emetery, cre	matory or other plac oln Crema		3/24/	2006 1	Brentw	ood N	farvlar	nd
	ortan injury		21. Signature of Funeral Service		110		Name and Address imple Tri							Id
ä	Dep Target		Me & C	h			imple Tri 040 Rockv	bute ille	Funer Pike:	al and Rockvi	Crema ille, l	tion (Maryla	Center and 208	352
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications tha	at caused the deat								Approximate Interval Betw	/een
Pr	iysician	0	Immediate Cause (Final disease or condition	_	creatic (_							Onset and De	eath
	Medical xaminer		resulting in death)	Due	to (or as a conseq	uence of):								
	Adillilici	_	Sequentially list conditions,	b	to (or as a conseq	uence of):						-		
pet	nsit	n in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a conseq	derice ory.								
), execu	n and ial-tra	Examiner	that initiated events resulting in death) Last	c	to (or as a conseq	uence of):			· · ·			-		_
8760,	physicien and the burial-transit	cail		d										
9 ≅	ng ph	Medi	IF FEMALE:											
Box Bath cert	ettending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	outcome of pregna e birth 2 ☐ Feta	death 3	Ectopic pregnancy					ate of delive	•	ear
O 5	by the e	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		agnant at time of d iknown	leath 5	Other (specify)							
ecords, P.O.	detac		Part II. Other significant condition	ens contributing to	death but not res	sulting in the u	inderlying cause give	en in Part I.		23e. Did tob	oacco use coi	ntribute to th	ne cause of de	ath?
ds,	sign Id be	d by								1 □ Y€	s 2 🙀 No	3 🗌 Prob	ably 4 □U	nknown
Records,	s been si should	Completed	9							24a. Was a		. Were auto	psy findings a	vailable
Œ ª	age age	шо								autops perform	ned? ∑⊠ No	death?	npletion of ca 2□ No	use of
	certifice rector, p	Bec	25. Was case referred to medica examiner?					26. Place	of Death (Check only on				
of Vita Physicien:	rthis ce raldire	2	1 ☐ Yes 2 X No	Hospital: 1	☐ Inpatient 2 ☐	ER/Outpatie		4 NU		5 ☐ Reside) Hospi	_ce
		e E	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	g (M	ite of Injury fonth, Day Year)	28b. Time o Injury	Wor			d. Describe ho	ow injury occu	urred		
Division or Attending	death stor: /	cat	2 Accident investi 3 Suicide 6 Could	not be	ace of Injury - At h	ome farm st		Yes 2 □		f. Location (St	reet and Nun	nber or Rura	l Route Numb	201.
- 5	9 = -	Certification:	4 ☐ Homicide determ	ined bu	ilding, etc. (Speci	fy)	root, ladiory, omoc			City or Town				
Hospita	within 24 hours el To the Funerel D completely filled is	edical C		Examiner: On the			th occurred at the tin							
o Sp	o the	Me	29b. Signature and title of certifie				29c. Licens	e number		2	9d. Date sign	ed (Month,	Day, Year)	
) [JA.		1 Ke	~	m)	D356	35		N	March 2	20, 20	006 .	
1			30. Name and address of person	who completed c	ause of death (Iter	m 23a) (Type								Control of the Contro
			Joseph Kaplan,				Mill Roa	d; Ro	ckvil	le, Mai	cyland	20855	<u> </u>	
ž	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 2	2006	2 Registrar's Sign	ature	ark							

State of Maryland / Department of Health and Mental Hygiene 0585 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death March 20° 2006° 20 **Physician** 11:10A. M Margaret A. Gorman /Medical 4a. Facility Name (If not institution, give street and number) Holy Cross Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 25, 1946 5 Social Security Number 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2**X**□ F 215-44-5103 59 Yrs Director Washington, DC Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. Count 10c, City, Town or Location 10a State 28a-1 show other treumatic event, the Medical Examiner must be notified at Frederick Maryland Monrovia 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 3897 Maryland Manor Drive 21770 United States or items 23a deeth v Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deel Department of Health and Mental Hygiene.
Important: If Item 27 is marked other the any Injury or other trainer. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White tf Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Cotlege (1-4or 5+) Collector JP Morgan Chase 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Lincoln Mehler Alma Gertrude Nussear 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jack A. Gorman -husband 3897 Maryland Manor Drive Monrovia, Maryland 21770 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metropolitan Crematory 3/20/2006 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald Vo Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faiture. List only one cause on each line. tmmediate Cause (Finat disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): Examiner Hypercalcemia Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Metastatic Breast Cancer Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical tE FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetet death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ğ Month Day Year 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the truneral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitat: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 □ FR/Outpatient 3 □ DOA 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 27. Magner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturat Injury 5 Pending within 24 hours after death. To the Funeral Director: At 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Tarifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and marrier as stated 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 56791 March 20, 2006 30. Name and address of person who completed cause of Fath (ttem 23a) (Type, Print) Luis Antonio Gonzalez, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 3. Registrar's Signature 22 MAR 2006 Registrar

			1 - For State Registrar		State of	f Maryla			nt of H		ind M	ental Hy	giene Reg. No.	06	do right of grand	058	5
ı	Physici	an	1. Decedent's Name (First, Middle	, Last)		Gedo	cah					2. Date of De Month	Day	2 ve		3. Time of	
	/Medic		4a. Facility Name (If not institution	aina ete	eat and our		201	4h Cil	y Town or	Location o	f Doath	march	17	200 County of D		1 7 3 .	
	Examin	er	Shady Grove A	3		Hospi	tal	40.00		cullle						mery	
	Funeral		5. Social Security Number	6. Sex			. last birthday		ler 1 Year	If Under 2	24 Hrs.	8. Date of Birt	h		Birthpl	ace (State of	r Foreign
	Director		517-14-8381	1 🔯 N	4 2□F	84	Yrs.	Month	s Days	Hours	Min.	(Month, Da May 9,			Count nta	ry)	
	2		Usual Residence of Decedent														
	arylar	٠	10a. State 10b. County			10c. C	ity, Town or L	ocation							10	ld. fnside Cit 11 Yes	
	8a-1	Director	Maryland Montgo	mery	7	Ga	ithers										2 🗆 140
	with th	ä	10e. Street and Number						Zip Code				10g. Citiz	en of What	Count	ry?	
	• 23c	rai	403 Russell Aven			dent Ever in	11.5		20877		-1-2/0			ed St			
	iter de	Funeral	11. Marital Status 1⊠Never Married 2 Marri		Armed Fo	rces?	0.5.	If Yes, sp	ecify Cuba	n, Mexican	, Puerto i	cify Yes or No Rican, etc.)	'	Black, V			
336	urs af	by	3 Widowed 4 Divorced		If Yes, Giv Year or Da	9		1 Yes	2 ☑ No	Specify:				Specify:	Wh	ite	
Ď	within 72 hours after death with the Maryland ene. then "naturel", or Iteme 23s or 28s-1 ehow in Medical Exercit or most be notified at	Completed	15. Decedent						ual Occupa			-	16b. Kin	d of Busine			
215	thin 7	pie	(Specify only highes Elementary/Secondary (0-12)	grade	Coffege (1	-4or 5+)	life.	DO NOT	use retired	during most)	OF WORK!	ig					
2	e filed within at Hygiene. other then "	် ပ			4		Acc	ount	int					ounti	ng		
Ind	be filed within 72 hours after death with the Marylar ital Hygiene. Indicate then "naturel", or Iteme 23a or 28a-1 show event, the Medical Examinating the notified at	Be	17. Father's Name (First, Middle, I	_ast)								(First, Middle,	Maiden S	Sumame)			
<u> Y</u>	should be and Mental marked umatic ev	ျ	William O. Gedos						/=	Mati						-	
Mai	d 2 st th and 7 le n treun		19a. Informant's Name/Relationsh			,						/ Route Numb				Code)	
e, –	1 and Healt Healt ther		Joseph R. Rezas 20a. Method of Disposition	n (F	riend	4	Place of Disp	osition /A	ame of		-	Frederi		1D 21 ation - City		vn. State	
ō	nt of I: # It		1 ☐ Burial 2 🛣 Cremation		moval from	State	cemetery, cre	matory o	other place					•			
Baltimore, Maryland 21215-0036	nit. P artme ortan Injury		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service t			Me						2-2006 7o1 Fun			а,	/irgin	11a
Ba	permit. Peges 1 and 2 should be Department of Health and Menta Important: if Item 27 Ie marked any Injury or other treumatic events.		111.42	1/1) NG1	•	10	Eas	t Dee	er Pai	kDi	iye	CLUI	Home			
			23a. Part1. Enter the disease, or	complica	tions that c	aused the dea							rrest,			Approximate	
	Pnysician		shock, or heart failure. List Immediate Cause (Final	only one	cause on e		Mann									Onset and D	eath
	/Medical		disease or condition resulting in death)	a	Due to (or as a conse	nonia quence of):								+	& W.E	29.
П	Examiner		Sequentially list conditions	b													
-	D ∺	lner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying		Due to	or as a cons	quence of:										
	death certificate be executed e attending physician and nd for use as tha burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. ,	Due to (or as a conse	ouence of):								-		
8760,	be ey ician buria				000 (0 (01 43 4 001134	iquanica on).								B		
687	icate phys s tha	edical		d.											+		
Box (eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	230	. If yes, out	come of preg							2:	3d. Date of	defive	v	
	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 Pregn	inth 2 ∏ Fe ant at time of		_]Ectopic _] Other (pregnancy specify)					Month		Ďay Y	'ear
o.	that the de ned by the a detached f	hys	9 Unknown	1	9Li Unkno	OWN											
o.	requires that the veen signed by th hould be detache	by P	Part II. Dther significant condition		A		sulting in the	underlying	cause give	en in Part I.		23e. Did t	obacco us	e contribut	e to the	e cause of de	eath?
ğ	w require been signature	ted	Coronary Ar	tery	Dise	ase						10'	Yes 2	No 3□] Proba	bly 4 □U	nknown
S	S E	Completed	malnutrit	101								24a. Was		24b. Were	autop	sy findings a	available
œ —	The ate h page	М										perfo	rmed?	deat	ነ?	2□ No	
/ita	ilcian: Th certificate rector, pag	Be (25. Was case referred to medical examiner?							26. Pface	of Death	(Check only o	ле)				
=	2 0 7	ို	1 ☐ Yes 2 XNo	Ho			☐ ER/Outpatie			4 🗀 140		ne 5 Resi			Specify		
Ĕ	Miter	inol in	27. Manner of Death 1 Manual 5 ☐ Pending		28a. Date ((Mont	h, Day Year)	28b. Time o Injury		28c. Injury Work			28d. Describe l	now injury	occurred			
isic	Attending or deeth. ctor: After by the fune	icat	2 Accident investig	ot be	28a Pface	of foius, - At	home, farm, st	M		Yes 2 ☐ î	-	28f. Location (Street and	Numbero	r Dural	Pouto Numi	hor
Division of Vital Records,	of or Attendiate deeth Director: A	Certification:	4 Homicide determi	ned	buildi	ng, etc. (Spec	cify)	ireet, raci	ary, onice		1.	City or To		7.47.11.007.01	, iora,	110010 140111	J 0 1,
	Hospitel of 24 hours at Funeral Distely filled i		29a. Certifier Certifyin	g Physic	ian: To the	best of my kr	nowledge, dea	th occurre	d at the tim	ne, date an	d place, a	and due to the	cause(s)	and manne	r as sta	ited.	
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical I	Examine	er: On the ba	asis of examir	ation and/or in	rvestigation	on, in my op	oinion, deat	th occurre	ed at the time,	date and	place, and	due to	the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certifier					2	9c. License	-				signed (M		lay, Year)	
)	13		Puscelala	lla	han-	Lyan	mp			4179			ma	rch 1	8	2006	
			30. Name and address of person of Priscilla Call	who com	pleted caus	e of death (fte	om 23a) (Type	Print)	uc w	II Aux	Shuc	Gait	ters h	um (ทก	ans	79
	Sta	te	31. Date filed (Month, Day, Year)		32.	bgistrar's Sign		(W	1			3411	J 4P	11.		~~~	/ 1
	Registr		WAR 2 2	3 200	16	State of	15 B	A SALE									

Leroy T. Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend unpend item#1,23a PIT 27 pen/F 2857 4/27/06 TT.

State of Maryland Department of Health and Mental Hygiene 06-02177 crn Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 2006 5:30 Ам Leroy Thomas Green, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wicomico Peninsula Regional Medical Center Salisbury 7. Age (In yrs. last birthday) | ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**⊠** M 2□ F Yrs. 216-70-2221 46 Director MD Usual Residence of Decedent 10d. fnside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County r 28a-f ehow 1 Yes 2 No MD Wicomico Salisbury Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 r than "naturel", or items 23a or the Medical Examinar must be 607 S. Westover Drive 21801 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No Air If Yes, Give Year or Dates: Force 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ¥No Black Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Force Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction Worker Home Improvement 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be le marked Leroy T. Green, Sr. 2 Marva Ames 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health a Itsm 27 I Marva A. Green/mother 607 S. Westover Drive, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of F Important: If Its any injury or ot once. 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify)

21. Signature of Fune)a sice MD Veterans Cemetery 4/4/2006 Hurlock, MD 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive cardiovaccular in the mode of dying areas, and a consequence of the cardiovaccular in the mode of dying areas. Lewis N. Watson Funeral Home Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** by gastrointestinal bleeding /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): .O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cirrhosis of liver 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ∠ Yes 2 □ No 1 X Yes 2 🗌 No 25. Was case referred to medical examiner?
1 2 Yes 2 No 26. Pface of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 After this 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification; 5 Pending 1 ☐ Yes 2 ☐ No death. investigation I Director: , 2 Accident 6 ☐ Could not be 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 [] Homicide

within 24 hours after or To the Funeral Direct completely filled in by Medical

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)
MAR 3 1 2006 32. Pagistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 30, 2006

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

		1	For State Registrar		S	state o	of Ma	ryland		artmen			and M	lental Hy	giene Reg. No	UUT)	105	38
			Decedent's Name (F	First, Middle	e, Last)									2. Date of De	ath Da	v	Year	3. Time o	of Death
	Physicia		Cather	ine 1	Marjo	rie	Gor	such						March	29,	2006	5	2:23	A. ^M
	/Medic Examin		4a. Facility Name (If no	ot institution	n, give stre	et and n	umber)			4b. City,	Town, or	Location of	of Death		40	. County			
			627 An	drews	Road	l					erde							ford	
	Funeral		5. Social Security Num		6. Sex	2√2 F	7. Age		st birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Dec •	th ay, Year)	1001	9. Birth	place (State intry)	or Foreign
ш	Director		177–16–5		1 L M	-X		84	Yrs.					Dec.	31,	1921	Pen	nŝylva	ınıa
	and w	-	Usual Residence of De 10a. State 1	ob. County				10c. City,	Town or Lo	ocation								10d. Inside C	City Limits
	Aaryli Fsho	5	MD	Har	ford			Abe	rdeen									1 🙀 Yes	2 🗆 No
	the !	Director	10e, Street and Number							10f. Zip	Code			I	10g. Ci	tizen of W	hat Cou	intry?	
	3a or		627 An	drews	Road	4				21	001				U	.S.A	•		
	hours after death with the Maryland tural; or Items 23a or 28a-f show al Ezatrither Hust be multified at	Funeral	11. Marital Status	arewo		Was De		ver in U.S	S. 13.			ispanic Ori	igin? (Sp	ecify Yes or Ne Ricen, etc.)	o-			ican Indian,	
9	or Ite	F	1 🗀 Never Married	2 Mari	ried	Armed F 1 Yes If Yes, G		0		1 Yes		Specify:		ricen, etc.)		Specify:	k, White		
03	ral', c	l by	3 Widowed 4 [Divorced		Year or	Dates:			163	223110	ороспу.					AATTT		
5	72 na	Completed	15 (Specify	5. Deceden	it's Educat st grade c	ion <i>ompleted</i>)		(Give	dent's Usua kind of wo	rk done d	during mos	t of work	ing	16b. F	(ind of Bu	siness/li	ndustry	
12	within lene. than "	du	Elementary/Second	ary (0-12)		College	(1-4or 5	+)		DO NOT us		"			Tn	hom	0		
2	be filed withir ital Hygiene. id other than event, the M.		12 17. Father's Name (Fin	rst Middle	(ast)	0			HOME	maker		18. Mothe	er's Name	e (First, Middle					
anc	ould be f Mental I warked of	Be C	Charle			ck					i			nes Cra					
Maryland 21215-0036	ë D E E	ဥ	19a. Informant's Nam						19b. Maili	ng Address	(Street a	and Numb	er or Rur	al Route Numb	er, City	or Town,	State, Zi	ip Code)	
<u>∞</u>	and 2 sealth arm 27 is		Mary G.Un				nter)	32 F	ort H	loyle	9	Jopp	pa, MD	210	85			
ē,	s 1 and 2 of Health item 27 I		20a. Method of Dispos	sition					ace of Disp metery, cre	osition (Nar	ne of	(a)		Date	20c. L	ocation -	City or T	Town, State	
e E			1 StBurial 2 🗆 4 🗆 Donation 5			noval from	n State	Harf	ord M	Memori	al C	dns,	4/1/0)6	Aber	deen	, Ma	aryland	E
Baltimore,	e ini	Ī	21. Signature of Fune					-	2	2. Name ar	nd Addres	ss of Facili	ety	nowol II	omo	D 7			
ä	Pen Imp gany		Mara	('	3e	Uh	Nau	2	104	Abero	.ng-C leen .	argo Mar	vlan	neral H 1 2100	1-33	99°A	•		
			23a. Part1. Enter the shock, or heart f	disease, of	complica t only one	tions that	caused each lin	the death							arrest,			Approxima Interval Be	etween
	Physician	6 (1	Immediate Cause (Findisease or condition		,	B	-	110	Lyn	phon	na						1	Onset and	34 2
	/Medical		resulting in death)		(a	Due to		consequ										0 -4,	V 1 1
В	Examiner		Sequentially list cond	itions.	b														
T	p ti	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly	ring	Į	Due to	o (or as	a consequ	ence ot):										
V	and -trans	каш	that initiated events resulting in death) La:		с	Due to	n (or as	a consequ	ence of):										
60,	be executed sician and burial-transit	ical E					. (0. 50												
68760	ate Ne he				d														
×	death certitics attending ph d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent p	roan ant	230			of pregna		_						23d. Dat	e of deli	very	
Вох	atter 1 for u	clar	in the past 12 m	onths?				2 Fetal time of de		⊒Ectopic p ⊒ Other <i>(s</i> ;		/				Moi	nth	Day	Year
o.	that the de ed by the detached	lys	9 Unknown	40		9 Unk	nown												
۳,	es that igned b	by Pi	Part II. Other significa	ant conditi	ons contr	buting to	death b	ut not resu	Ilting in the	underlying o	ause giv	en in Part	l.	23e. Did	tobacco	use contr	ibute to	the cause of	death?
rds	quires in signi	pe pe	Hyper	lensio	_									1 🗆	Yes 2	Dip	3 ☐ Pro	obably 4]Unknown
Records,	law requir as been si 2 should	olet	atria	1 Fib	rillat	Man								24a. Wa	s an opsy	24b. V	Vere au	topsy findings	s available
Re	9 2 9	Completed													ormed?		leath?	2□ No	04430 01
Vital		0	25. Was case referre	d to medica	al							26. Plac	e of Deal	h (Check only		-			
>	Physician: this certiticanal director, I	To B	examiner? 1 🗌 Yes 2 🗎 N	0	Hos	spital: 1 [] Inpatie	nt 2 🗆	ER/Outpatie	ent 3 De	Oth Oth	ler: 4□N	ursing Ho	ome 5 es	idence	6 □Oth	er (Spec	city)	
n of	ding Phys T. Atter this funeral di		27. Manner of Death 1 ₩ Natural	5 🗆 Pendi	na	28a. Dat (Mo	te of Inju	y Year)	28b. Time Injury	of :	28c. Injur Wor			28d. Describe	how inj	ury occurr	ed		
Sio	Attending or death. ector: Atter by the fune	catl	2 Accident		igation					М		Yes 2	JNo	006 1	/04				
Division	or Att	Certification:	4 Homicide	deterr				ry - At ho c. (Specify	me, farm, s	treet, factor	y, office			28f. Location City or To			er or Hu	rai Houle ivui	mper,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certitic completely tilled in by the funeral director.		29a. Certifier	Acarica:	na Physic	ian To	he heet	of my kno	wladza do	th occurre	l at the ti-	me date a	nd place	and due to the	a cause/	s) and mo	nner ac	stated	
	To the Hospital within 24 hours a To the Funeral I completely tilled	Medical	(Check only 2 one)	Medica	I Examine	r: On the	he best basis of anner sta	examinal	tion and/or i	nvestigation	n, in my c	pinion, de	ath occur	red at the time	, date ar	nd place,	and due	to the cause	(s)
	thin (Mec	29b. Signature and til	tle of certific	er _ ^		2111101 011			29	c. Licens	e number			29d. D	ate signe	(Mont	n, Day, Year)	
	⊬ ≯ ⊬ 8		people	and		Dea.	~				0000	4809	50		-	3/291	06		
•	12		30. Name and address	s of person	n who com	pleted ca	use of d	eath (Item	23a) (Type	, Print)									
	10		Prashan	1 . 0	nukla	i, m	0 11	5 · Sc	outhf	birke.	Street	etAh	erde	en no	210	101			
	Sta	ate	31. Date filed (Month			32	gistr	ar's Signa	ture	1 0									
	Regist	rar	A	PR 0	5 200	16	The Car	100	J. 14	MARK	p*					_			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland		artmen <i>tificat</i>			and M	_	gien Reg. N	UUb	No. of Approximate	0589	
			Decedent's Name (First, Middle, Last)					-			2. Date of De	ath			3. Time of Death	_
	Physici /Medic		Deborah Ann	Lail Go	lwav						March	Da 1	-	₀₀₆	2:53PM	đ
	Examin		4a. Facility Name (If not institution, give s				4b. City,	Town, or	Location o	f Death	ALICA DIII		c. County of			_
			Civista Medica	1 Cente	er			La	P1at	a			(Char	cles	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. las 50		If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir	th y, Year	7.055	Birthp	lace (State or Foreig try) Shington	n
	Director			M 2 F	J 0	Yrs.					June .	10,	1935	was	snington	ע
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Town or Lo	cation							1	0d. Inside City Limits	
	Aaryl f sho	ō	MD Charle	s		wburg									1 ☐ Yes 2 😾 No	
	tha f	ect	10e. Street and Number				10f. Zip	Code				10a C	itizen of Wh	at Coun		
	with 3a or	Funeral Director	12884 Marie Dr	ive				0664							,	
	ms 2:	era		12. Was Decedent	Ever in U.S.	13. \				gin? (Spe	ecify Yes or No Rican, etc.))-	USA 14. Race -		an Indian,	_
0	uftar (Fur	1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 ☐	No					, Puerto	Rican, etc.)		Black,	White,	etc.	
3	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	21XNo	Specify:				Specify:	W	nite	
ည် က	be filad within 72 hours after death with the Maryland ital Hygiene. Id other then "netural", or items 23a or 28e-f show event, the Medical Examinar must be motified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)		16a. Deced	lent's Usua	I Occupa	ation during most	of worki	ina	16b. l	Kind of Busi	ness/Inc	lustry	_
7	ithin Ne.	npi	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life.	OO NOT us	e retired)		9					
2	filad wil Hygien other th		47 Fatherto Name (First Address Land)	1			Hor	nema	ker		(E)			lome	<u> </u>	_
20	ba fi	Be	17. Father's Name (First, Middle, Last)	7							(First, Middle,					
3	should ba filad nd Mental Hygi s merkad other umatic evant, I	၉	James Paul Lai					(-		nie						
<u>a</u>	12 sho h and 7 Is m traum		19a. Informant's Name/Relationship (Ty)				-				l Route Numbe				Code)	
ტ ტ	ges 1 and 2 should t of Health and Men If itam 27 is merka or other traumatic	-	Kenneth Golway,	III/Hus	band						wburg,		.ocation - Ci		wa State	_
Baltimore, Maryland 21215-0036	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State		e of Dispo										
	it. Partmer rtmer rtant njury		 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service License 	. NO	Brir	istie	ld-E	cho	1s 3	/18	/06 C	Chai	rlott	e F	[all,MD	_
g	parmit. Pages Department of Important: If i any injury or once		21. Signature of Puneral Service Cicense	L MO	0945	ΑÏ	EHAF	T-E	CHOL	S F	UNERAL	. H(OME.P	A		
			23a. Part 1. Enter the disease, or compli	cations that caused	the death	P. Do not ent	O. I	of duine	567,	La	Plata	, MI	2 06	46	Approximate	-
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each lir	ne.					our diao c	n rospiratory at	11031,			Interval Between Onset and Death	
)	Physician /Medical		disease or condition resulting in death)	Cardi			y Fa	iilu	re							
	Examiner			Due to (or as Conge			rt E	'ail	1120							
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as			1 6 1	атт	ure							
	utad d ansit	盲	cause. Enter Underlying Cause (Disease or injury that initiated events	Breas	t Can	cer	Meta	sta	sis						5 years	
~	exec in an	Examiner	resulting in death) Last	Due to (or as	a consequer	nce of):									Jears	
8/60,	The law requiras that tha death certificate be executad ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai														
Õ	rtifica ng ph as th	Med	IF FEMALE:													_
ŏ	leath certific attending p I for use as	an/	23b. Was decedent pregnant 23	3c. If yes, outcome 1 ☐ Live birth			Ectopic pr	egnancy					23d. Date of		,	
ה מ	a dea he at	sici	in the past pmonths?	4□Pregnant at 9□Unknown			Other (sp						Month	1	Day Year	
л О	at tha de d by the a stachad	Physician/Me	9 Unknown													
Ś	signed to	by	Part II. Other significant conditions con	tributing to death bi	ut not resultir	ng in the ur	nderlying ca	ause give	n in Part I.						e cause of death?	
cords	w requir been si should	ted									101	Yes 2	XNo 3	☐ Proba	ably 4 □Unknown	_
ပ္	law lasb	npie									24a. Was autop	SV	pric	or to con	sy findings available)
<u> </u>		Completed									1 Yes	rmed?		th? Yes	2□ No	
VItal	yaician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	on-ital:				0.1		of Death	(Check only o	ne)				_
O	Phya this al dir	2	T Tes ZA No	ospital: 1 Inpatie		VOutpatien			4 🗆 1401		me 5□Resid)	
	ding P	ion	27. Manner of Death 1 XNatural 5 □ Pending	28a. Date of Injur (Month, Day	y Year)	3b. Time of Injury	м 2	Bc. Injury Work			28d. Describe I	now inju	iry occurred			
<u>S</u>	death death stor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Place of Inju	une - At home	a farm etr			res 2□N		29f Location /	Stroot 3	ad Number	or Pural	Route Number.	_
DIVISION	l or A after Dirac	Certification:	4 Homicide determined	28e. Place of Injubulding, etc	c. (Specify)	5, Iaiii, Siii	et, lactory	, onice		1	City or Tox			or nurar	noute Number,	
	spita nours naral		29a. Certifier 12 Certifying Phys	ician: To the best of	of my knowle	edge, death	occurred a	at the tim	e, date and	d place, a	and due to the	cause(s	and mann	er as sta	ated.	
	To the Hospital or Attanding Phyaician: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral diractor,	edicai	(Check only Medical Examin	er: On the basis of	examination	and/or inv	estigation,	in my op	inion, deat	h occurr	ed at the time,	date an	d place, and	d due to	the cause(s)	
	To t To t	Σ	29b. Signature and fittle of certifier	This	h o	6./	290	License	number	17 1	01	29d. Da	te signed (/	Month, L	Day, Year)	
	16		Muller	HW1.	My,	M	<u> </u>	20	06	91	0/	_(3	115	1/0	0	
	1210		30. Name and address of person who co						_				10 1	0		
			Stacie Gump, M. I				e Cer	nter	,Sui	te	302,Wa	ald	orf,M	1d 2	20602	
	Sta Registr		MAR Z 1 20	Ub 32 Hegistra	ar's Signatur		3									

		1	For State Registrar	State of Ma	arylan	•			ealth and Death		Reg. No.	1)	0390
f	Physici /Medic	an	Decedent's Name (First, Middle, La	Melvin F	۲. G	ough				2. Date of De Month Ma	nath Day r 18, 2006	Year	3. Time of Death 1520 M
	Examin		4a. Facility Name (If not institution, giv				4b. City,		Location of Deal		4c. Count	y of Death Calv	ert
	Funeral Director		5. Social Security Number 217-07-6634 6. S		e (In yrs. 89	last birthday) Yrs.	If Unde Months	r 1 Year	If Under 24 Hrs Hours Min.	8. Date of Bir	v. Year)	9. Birth	olace (State or Foreign htry) Maryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Maryli -f sho	ţō	MD Cal	vert					Dowell				1 □ Yes 2 No
	a with the	Funeral Director	10e. Street and Number 13415 Dowell Road				10f. Zi	p Code	20629		10g. Citizen of	What Cou U.S.A	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "naturel", or items 23a or 28a-f show stent, it e Madical Examiner must be notified at	Ď	11. Marital Status 1 Never Married X Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? Y Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Was Dece If Yes, spe 1 Yes		ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	Bla	ce - Ameri ack, White, ify: Black	etc.
5 0	72 ho 'natur	eted	15. Decedent's E (Specify only highest gra	ducation de completed)		16a. Dece	kind of w	ork done d	during most of wo	rking	16b. Kind of I	Business/In	dustry
2	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT I		Driver		P	ublic W	orks
Maryland 2	od stal	Be	17. Father's Name (First, Middle, Last	ohn Parran Go	ugh				18. Mother's Na	me (First, Middle Emn	n, Maiden Suma		
ary	s 1 and 2 should be f Health and Mental item 27 is marked o other traumatic sve	2	19a. Informant's Name/Relationship	Type, Print)						ural Route Numb	er, City or Town	n, State, Zij	Code)
	ロボトサ		Michael Gough		Son				Dowell, MI	Date Date	On Leastine	City of T	- Ctato
Baltimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition X Burial 2 Cremation 3 C 4 Donation 5 Other (Speci		1	Place of Dispo cemetery, crei St. John U				3/25/06	20c. Location	Lusby,	
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Lice Jladen G.	Sevell		22	Se	well Fu	ss of Facility Ineral Home es Beach R	e oad Prince	Frederick, I	MD 206	78
68760,	Medical Examiner bhysician and sthe burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Hyper to (or as c. Due to (or as d.	a conseq	quence of):	Arr	hy t lio (hmi'a Kusurla	n dis	ease		Onset and Death
P.O. Box 68	The law requires that the death certifics are has been signed by the attending pt cage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3[⊒Ectopic ⊒ Other (s		,			eate of deliving	rery Day Year
	signed by		Part II. Other significant conditions			_	ındəriying	cause giv	en in Part I.				the cause of death? bably 4 @Unknown
of Vital Records,	he law requir e has been si age 2 should	Completed by	Dementia.				_			24a. Wa auto pen 1 \subseteq Yes	s an 24b opsy ormed? 2 No	prior to co death?	opsy findings available ompletion of cause of
ita	ian: Trificat	Be C	25. Was case referred to medical						26. Place of Di	eath (Check only			
<u>></u>	hysic this ce al direc	10	examiner? 1 Yes 2 No	Hospital: 1 Inpati		ER/Outpatie			4 🗆 Haraing	Home 5 Res			ify)
	ding P	lon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Inju (Month, Da		28b. Time o Injury	or M	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe	how injury occ	niiea	
Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not determined	OB Place of In	jury - At h tc. (Speci	nome, farm, st	reet, facto			28f. Location City or To	(Street and Nur own, State)	n <i>ber</i> o <i>r Ru</i>	ral Route Number,
	e Hospita 24 hours e Funeral letely filled	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best miner: On the basis of and manner st	of examina	owledge, deal ation and/or ir	th occurre	d at the ti	me, date and place pinion, death occ	ce, and due to the curred at the time	e cause(s) and r , date and place	manner as e, and due	stated. to the cause(s)
j.	To th Withir To th comp	Me	29b. Signature and title of certifier	c.a	and	9 .	2		5 0 65	3	29d. Date sign		2006
	3+1		30. Name and address of person who			m 23a) (Type		GYF Od	Dea,	SURM 1e MI	NA 20	751	
	· St	ate	31. Date filed (Month, Day, Year)	32. Regist	ray's Sign	ature	So	arti	в				

			For State Registrar	State of Man		ertificate of I			ene No. 0 0 6	10591
	Dhuaisi		1. Decedent's Name (First, Middle, Last	')	·			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic			Harvey				March 16	5, 2006	8:27 a ^M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Clinton	Location of Death		4c. County of Death Prince Ge	Orga
	Fundad		Southern Marylan 5. Social Security Number 6. Se		n yrs. last birthday		If Under 24 Hrs.	8. Date of Birth	Q Right	Inna (Ctata or Foreign
	Funeral Director			□M 2∏ F	84 Yrs.	Months Days	Hours Min.	Sept. 15	, 1921 Mary	land
	D >		Usual Residence of Decedent 10a. State 10b. County	1/	c. City, Town or I	anation				
	aryla ehov	2							'	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the N 28e-f	Director	Maryland Prince G	eorges	Suitlar	10f. Zip Code		100	. Citizen of What Cour	21
	3 with	2	3940 Bexley Place	Apt. 310		20746			United Sta	
	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13	. Was Decedent of H. If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Americ Black, White,	an Indian,
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Ie marked other then "neturel; or items 23s or 28e-f ehow other treumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ॡ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 ☐ Yes 2 🙀 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify: B1a	
5-0	72 hc	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	16a. Dec	edent's Usual Occup e kind of work done o DO NOT use retired	ation during most of work	sing 16	b. Kind of Business/Ind	dustry
121	within ene. then "	mp	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		DO NOT use retired mestic Wo:			Private	
20	e filed within at Hygiene. I other then 'vent, the Ma		17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma		
lan	ld be ental ked o	To Be	Herbert S. Ducker	tt			Laura E	llen Jack	son	
Maryland	2 should and Men le marke	-	19a. Informant's Name/Relationship (7)		19b. Ma	ling Address (Street a			City or Town, State, Zip	Code)
	and 2 salth a n 27 le		Shirley Jones /Da			Rayburn l		e Hills,	Md. 20748	
Baltimore,	m O		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I	Removal from State	20b. Place of Disp cemetery, cr	oosition (Name of ematory or other place	(e)	Date 20	c. Location - City or To	own, State
ţ	tment tant:		4 ☐ Donation 5 ☐ Other (Specify,)		s AME Zio			denton, Md	•
Bal	permit. Page Depertment Important: If eny injury or once.		21. Signature of Funeral Service Licens	1000		X1exander 5538 Mar11			ome, P.A. 11e, Maryl	and 20747
			23a. Part . Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	death. Do not e	nter the mode of dyin	0 0			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	smy	bry +	ailum	e		Onsot and Doath
	/Medical Examiner		Todaling in doubly	Due to (or as a co	onsequence of):	0				
	*	e	Sequentially list conditions, if any, leading to immediate	b. Due to (ur as a ur	onsequenge of):	But I		λ .	2	
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. (C	irali	pulmo	nary	1)198	ease	
Ö,	e exerien ar urial-t	Ex	resulting in death) Last	Due to (or as a co	onsequence of):	,				
68760,	ficate be executed physicien and is the burial-transit	edical		d					-	
	= D #	/Me	IF FEMALE:	23c. If yes, outcome of g	pregnancy				22d Data of dollars	
Вох	death cert e attending ed for use a	Physician/M	in the past 12 months?	1□Live birth 2 ☐ 4□Pregnant at tim	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	Day Year
P.O.	that the de ed by the detached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown						
	res tha igned I be det	ру Р	Part II. Other significant conditions co	intributing to death but n	ot resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
Şrd	law requires as been sign 2 should be							1 🗷 Yes	2 No 3 Prob	ably 4 Unknown
Division of Vital Records,	0 - 0	Completed						24a. Was an autopsy performe	d?/ prior to co	psy findings available mpletion of cause of 2 No
/ita	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?			/ 10		th (Check only one)		
of	Physi this c	T.	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient	2 ER/Outpati		# [Ivuising ri		e 6 ☐Other (Specif	y)
Lo	ding I h. After funer	tlon	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yo	28b. Time ear) Injury	Worl	γat k? Yes 2 □No	28d. Describe how	injury occurred	
/isi	or Attending after death. Director: Afte in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	280. Place of Injury				28f. Location (Street	et and Number or Rura	l Route Number,
á	s afte	Certification;	4 Homicide	building, etc. (Specify)			City or Town, :	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one) 1 Certifying Phy one) 2 Medical Exam	ysician: To the best of n iner: On the basis of ex and manner stated	amination and/or	ath occurred at the tin investigation, in my o	ne, date and place, pinion, death occur	and due to the causered at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	e number	290	. Date signed (Month,	Day, Year)
)			1 (lballeran	uni N	W	DO 4	13606	0	3-21-1	06
2	4			completed cause of deat	1503 Suu 1503 Suu 1504 77		And the second s		U20735	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 2 200	Registrar's	Signature	eill)	1-11-1	VI 00 1 1 17		

			For State Registrar	State of Marylan			of Health of Deal			Rag. No.	6	10592
	Physicia		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Lila Lee Harmon			4h Cit. To	own, or Location	on of Death	March	17, 20		2:10 a M
	Examin	er	4a. Facility Name (If not institution, give stre			Laure		OIT OI DOGUT				orge's
112	Funeral	320	Laurel Regional Hos 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year If Und	der 24 Hrs.	8. Date of Birt (Month, Da	h		place (State or Foreign
	Director		170-36-3161 ^{1□ M}	² ∑F 63	Yrs.	Months I	Days Hour	rs Miri.	April	10, 1942	Penn	sylvania
	pur x		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
	daryla f sho	ō	Maryland Anne Arun	del Lau	rel							1 ☐ Yes 2 📉 No
	28a-	rect	10e. Street and Number	dol Had	ICI	10f. Zip C	Code			10g. Citizen of	What Cou	ntry?
	hours after death with the Maryland turet', or items 23a or 28a-f show al Examinational be notified at	Funeral Director	12 North Carol Stre	et		2072				U.S.A.		
	ems (iner	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deceder	nt of Hispanic y Cuban, Mex	Origin? (Spe tican, Puerto	cify Yes or No Rican, etc.)	- 14. Ra Bla	ce - Americk, White,	can Indian, etc.
36	s after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		1 □ Yes 2	X No Spec	cify:		Speci	v: Whi	ite
	hour	ed b	15. Decedent's Educal		16a. Dece	dent's Usual	Occupation			16b. Kind of E	Business/In	dustry
5	nin 72 n ni Madik	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work DO NOT use	done during r retired)	most of worki	ng			
2	er the	Com	12		Homen	naker				Own Ho		
n n	be file	Be	17. Father's Name (First, Middle, Last)							Maiden Suma	m <i>e)</i>	
Maryland 21215-0036	d Men narke	P P	Lee Roy Rayan 19a. Informant's Name/Relationship (Type	Print)	19h Maili	no Address (elma H:		er, City or Town	. State, Zii	o Code)
Z	d 2 si th an 27 is r traur		William J. Harmon -			3				, MD 20		
ē,	s 1 an I Heal Itam 2 other		20a. Method of Disposition	20b. F	 Place of Dispo cemetery, crei	osition (Name	e of ner place)	1 0	Date	20c. Location	- City or T	own, State
E O	Pages ient of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donati n 5 ☐ Other (S. ~ ify)	noval from State				March	21, 2006	Chelte	nham,	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "natural", or items 23a or 28a-f show any joury or other traumatic event, the Madical Examination use to confide at any injury or other traumatic event, the Madical Examination use to confide at any injury or other traumatic event, the Madical Examination uses the page.		21. Signatury of Funeral Service Licensee		22		Address of Faltimo	G		Funeral yattsvi		e, P.A. MD 20781
	en di		23a. Part1. Enter the disease, or commica shock, or heart failure. List only one	tions that caused the deat cause on each line.	h. Do not en	ter the mode	of dying, such	h as cardiac d	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Two Stage I	∟iver (Cirrhos	sis					011301 0113 250011
	/Medical Examiner		resulting in death)	Due to (or as a consec								
		e.	Sequentially list conditions, if any, leading to immediate	Renal Failu								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
oʻ	te be executed ysician and le burial-transit	Exa	resulting in death) Last	Due to (or as a consec	quence of):							
8760,		licai	d.									
9	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 230	c. If yes, outcome of pregn	ancv					234 0	ate of deliv	(ADV
Вох	atten	clan	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	aldeath 3[□Ectopic pre □ Other (spe					lonth	Day Year
o.		hysi	1 ∐ Yes 2 ဩ No 9 ☐ Unknown	9□ Unknown					-			
S, D	requires that the been signed by th hould be detache	by P	Part II. Other significant conditions conti	ibuting to death but not res	sulting in the u	underlying ca	use given in P	Part I.				the cause of death?
ord	w require been signal								1111	Yes 2 □ No	3 [] Pro	obably 4 MUnknown
Record	aw is b	Completed							24a. Was		. Were aut prior to c death?	opsy findings available ompletion of cause of
E H	Th age pag								1 ☐ Yes	2∑ No	1 🗌 Yes	2□ No
Vital		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	spital: 1 🔀 Inpatient 2	ER/Outpatie	ent 3 DO	Other		h <i>(Check</i> on <i>ly</i>	one) idence 6 □O	ther (Saec	rify)
of		 -	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		Bc. Injury at Work?	Truising He		how injury occi		
ion	Attending Firdeath. ector: After by the funer	atio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Monus, Day Year)	Injury	м	1 ☐ Yes	2 □No				
Division	* 9 E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Special	nome, farm, si	treet, factory,	, office			(Street and Nun wn, State)	nber or Ru	ral Route Number,
	To the Hospital c within 24 hours af To the Funeral D completely filled in	Medicai C	29a. Certifier 1 X Certifying Physi (Check only one) 2 Medical Examina	cian: To the best of my kn er: On the basis of examin and manner stated.	owledge, dea ation and/or i	ith occurred a nvestigation,	at the time, da in my opinion	te and place, , death occur	and due to the red at the time	cause(s) and i , date and place	manner as e, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	DO11/11	5	29c.	. License num	nber		29d. Date sign	ned (Month	. Day, Year)
			I CHA	Coly W		D	53987			March	18,	2006
R	(3)		30. Name and address of person who con							0100		
				300 Armory			3G, B	altimo	re, MD	21201	-	
	St Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 1 2006	2. Registrar's Sign	Apre	1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 8:45 PM 2006 MARCH Cornelia E. Husfelt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year)

April 27,1925 Ceci1 Sun If Under 2 Calvert Manor Rising
If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2√2 F 80 Director 216-20-2092 MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic evant, the Medical Examiner must be notified at 1 ☐ Yes 2x No Director MD Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 601 Ricketts Mill Rd. or Itams 23a 21921 death U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural, or Ital ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White à 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) C&P Telephone Co. Supervisor 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles T. Weldin Cornelia E. Sloan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is m any injury or other traum once. 601 Ricketts Mill Rd., Elkton, MD 210 Date 20c. Location - City or Town, State Thomas N. McIntire/Friend 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State March 27, Elkton, MD 4 ☐ Donation 5 ☐ Other (Specify) Gilpin Manor 22. Name and Address of Facility 2006 21. Signature of Figheral Service Licensee Andrew G. Gee Funeral Home 23a. Part 1. Ander the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest. N MD shock, of heart failure. List only one cause on each line. 2 Appreximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA - ALZHEIMER TYPE unk /Medical Due to (or as a consequence of): **Examiner** Supremitally list on altions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year ō in the past 12 months? 1 ☐ Yes ②☑ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown ate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 🗌 Yes 2) No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centier

State Registrar

DHMH 17 Rev 1/2001

5

TELECRIAPH ROW

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1831

oistrar's Signature

RODNEY DONHAM, D.O.

31. Date filed (Mo

H58419

RISING SUN MD

MARCH 22, 2006

			1 - For State of Registrar	Maryland /			f Health a of Death	nd Me		iene	10594		
4			Decedent's Name (First, Middle, Last)					2	2. Date of Deat Month	Day	3. Time of Death		
	Physici /Medic		CECIL M. HAY					N	IARCH .	18, 200	06 2005 M		
Á,	Examin		4a. Facility Name (If not institution, give street and number				n, or Location of						
			Shady Grove Adventi	st Hosp	ital		ckvill			MON	rgomery		
-	Funeral Director		5. Social Security Number 053-50-8745 6. Sex 1 M 2 1 M 2 1 F	. Age (In yrs. last I	birthday) _ Yrs.	If Under 1 Ye Months Da		Min.	B. Date of Birth (Month, Day, Apr. 23	Birth Day, Year) 23,1943 9. Birthplace (State or F Country) Jamaica			
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	our or Loc	oation			8		10d Incide City Limite		
	aryla ehov	_	,	Toc. City, 10									
	Ba-f	Director	MD Montgomery		MC		ery Vi	TTag					
	or 2	100	10e. Street and Number			10f. Zip Cod			11		,		
	ath v	ra	9207 Turtle Dove La				20886						
	er de	Funeral	Armed Ford	lent Ever in U.S. es?	13. V	Vas Decedent (Yes, specify C	of Hispanic Origi Cuban, Mexican,	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)				
36	s afte	by F	1X Never Married 2 Marned 1 Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Date	No.	1	□Yes X□	No Specify:			Specify:	2006 2005 M Country of Death MONTGOMERY 9. Birthplace (State or Foreign Country) Jamaica 10d. Inside City Limits 12 Yes 2 No en of What Country? U.S.A. 4. Race - American Indian, Black, White, etc. Specify: Black d of Business/Industry edical Sumame) Town, State, Zip Code) antown, MD ERAL HOHE, F.A. 11e, MD 20850 Approximate Interval Between Onset and Death Onset and Death Completion of cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Other (Specify) occurred		
5-0036	filed within 72 hours after death with the Maryland Hygien. titer than "naturel", or items 23s or 28s-f show ont, the Madical Exeminer must be notified a	d be	15. Decedent's Education		62 Deced	ent's Usual Oc	tounation						
7	"nat	Completed	(Specify only highest grade completed)	16	(Give I	kind of work do NOT use re	one durina most	of working	7	160. Kind of Bus	ness/industry		
2121	within Bne. then	E D	Elementary/Secondary (0-12) College (1-		Nor		ninou)			Medic	ra l		
N D	filed Hygid ther int,	e Co	17. Father's Name (First, Middle, Last)	5	1467	. 50	18. Mother	's Name (First, Middle, N	Maiden Sumame			
	m = 0 5												
2	houl d Me mark mati	ို	Joslyn Hay 19a. Informant's Name/Relationship (Type, Print)	1	9b. Mailin	a Address (Str	reet and Number	or Rural	el Mine	City or Town S	tate Zin Code)		
Maryland	d 2 s th an th an trau		Patrick Hsrris (Son)	1	9177	Warr	ior Br	ook	Dr., (Germant	own, MD 874		
بة	Heal Heal		20a. Method of Disposition	20b. Place	of Dispos	sition (Name of	f	Da					
altimore,	ages in a second		1 ☐Burial 2 ☐ Cremation 3 ☐ Remoyal from S	tate		atory or other 11s Ce		-27-	.06 (Cormant	Own MD		
≣	it. P.		4 ☑ Donation 5 ☐ Other (Specify) 21. Skriature of Funeral Service Licens (1 1									
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.		Clorge 1 suor	Hen									
	Physician		23a. Part1. Enter the disease, or complications that ca shock, or head failure. List only one cause on ea Immediate Cause Final disease or condition	ch line.							Interval Between Onset and Death		
	/Medical		resulting in death) Due to (o	r as a consequence	ce of):					4 (- de de		
	Examiner		Sequentially list conditions b.	+70 E	JVS	ensi	co,						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	r as a consequenc	ce of):			,					
	s be executed sicien and burial-transit	Examiner	that initiated events		03	1	11150	in	>				
760,	e exe		Due to (o	r as a consequenc	1	<u> </u>							
876	ate be ex hysicien the burial	Ica	d	1374	110	Sia							
9	leath certifica attending ph I for use es t	Physician/Medical	IF FEMALE:										
Вох	ath cert ttendin or use	lan/	in the past 10 months?	ome of pregnancy th 2 Fetal dea	ath 3□	Ectopic pregna							
0	the a	Sic	1 ☐ Yes 2 No 4☐ Pregna 9 ☐ Unknown 9☐ Unknown	nt at time of death vn	1 5□	Other (specify	v)						
<u>.</u>	res that the de signed by the a l be detached t	Ph	Part II. Other significant conditions contributing to dea	ath but not socution	a in the	dashina onya	a succe in Don't		23a Did toh	anno uno contrib	outs to the squee of death?		
Records,	res ti signe l be c	þ	Q NEW 1		y iii tiile uii	idenying cause	gyven ar ranti.		1 ☐ Ye	1			
5	w require been sig should t	Completed			0 .								
မ	e law has b	ם	Clastridism	- Cr	<u> 7, c</u>	(/2)	colit	17	24a. Was ai autops	y pri	or to completion of cause of		
=	ysician: The is certificate hi director, page	S							perform				
Ħ	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					of Death	Check only on	θ)			
\leq	Physi this c	ို			Outpatient	JUDON							
_	ding P h. After t funera	üo :	27. Manner of Death 28a. Date of (Month) 1 ★Natural 5 ☐ Pending (Month)	Injury 28t Day Year)	b. Time of Injury		Injury at Work?		ld. Describe ho	w injury occurred	1		
<u>s</u>	Attending or death. ector: After by the funer	cat	2 ☐ Accident investigation			М	1 Yes 2 N						
Division of Vital	el or Att	Certification:	determined 200. Place	of Injury - At home, g, etc. <i>(Specify)</i>	, farm, stre	eet, factory, off	fice	28	Bf. Location (Sti City or Town		or Rural Route Number,		
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: Attenthis certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifying Physician: To the to (Check only one) 29a. Certifying Physician: To the base and manner on the base and manner one)	sis of examination	dge, death and/or inv	occurred at the	ne time, date and my opinion, death	place, an	nd due to the ca d at the time, da	ause(s) and mani ate and place, an	ner as stated. Id due to the cause(s)		
	ithin o the	Me	29b. Signature and title of certifier			29c. Lic	cense number		25	9d. Date signed	Month, Day, Year)		
1			Mr. Gant			+1	11161	00					
,	5		30. Name and address of person who completed cause	of death /Itom 22	a) /Tuna 1	Print)	41101			ind ve	11 , (20.08)		
			30. Name and address of person who completed cause	1	1		Duine	. (72-1	nanter	NESOS and NI		
	Sta	to-	31 Date filed (Month, Day, Year) 32 Re	gistrar's Signature			~ 41 A C						
100	Registr		MAR 2 2 2006	me It	100	HE							

			1 - For State Registrar	State	of Marylar		artment of F		nd Mental Hy	/giene Reg. No.	Charles Charles	1059	5	
	Physici /Medio		Decedent's Name (First, Middle, L JUDY	ast) W • HOOP	ER				2. Date of D Month MARCH	Day		3. Time of De 10:40		
	Examin Funeral		4a. Facility Name (If not institution, g 17710 Town 5. Social Security Number 6.				4b. City, Town, o Gait If Under 1 Year	hers	burg		MONTG	OMERY	oreign	
Ì.	Director		224-88-8012 Usual Residence of Decedent	1□M 2 X F	48	Yrs.	Months Days	Hours	June 3	0 , 19	57 No	place (State or Fintry) rfolk,	VA	
	death with the Maryland ms 23a or 28a-f show rmust be coeffied at	Director	10a. State 10b. County MD Montge	omery	10c. Cit	ty, Town or Lo Gaith	nersburg	Ī				10d. Inside City L		
	ath with the 23s or 2		10e. Street and Number	rest Di	rive	304	10f. Zip Code 2087				zen of What Cou	•		
0030	ours after de el', or ttemt	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🗗 Divorced	Armed F	2 X No	'	Was Decedent of H If Yes, specify Cuba 1□ Yes 2☑ No	ispanic Origi in, Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Amer Black, White Specify: Black	, etc.		
0-61717	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Montlet Hygiene. Important: If term 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, its Medical Examination must be invitted at once.	Completed	15. Decedent's (Specify only highest g	rade completed,	1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most o	of working	Mon	nd of Business/li tgomery blic Sc	y Count	 -y	
yland	ould be filed Mentel Hyg arked other atic event,	To Be C		wood				18. Mother's		e, Maiden ard	Sumame)			
e, mar	l end 2 sh fealth and im 27 is m her traum		19a. Informant's Name/Relationship Melissa Coler			1771	ng Address (Street O Townconsition (Name of	and Number rest	or Aural Aoute Numb	Gai	thersb	irg, MD	377)	
Saltimore	t. Pages rtment of h rtent: if ite		20a. Method of Disposition 1	cify)	State	semetery, cren L1 Sou	natory or other place ILS Cem	3/	^{/25/06}	Ge:	cation - City or T	vn, MD		
0	Depa Depa impo sny i	-	23a. Part1. Enter the also ase, or co	Sin	reelei	/ 2	46 N. W	ashir	Snowden gton St	Roc	kville	,MD2085	<u>; 0</u>	
	Physician /Medical Examiner		shock, or heart feilere. List on Immediate Cause (Final disease or condition resulting in death)	a	ovaria (or as a conseq	ın Can		y, suon as oc	ardiac or respiratory i			Approximate Interval Betwee Onset and Dea 10Mont	ath	
,0070	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, it say, teaching to him ediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	c	(or as a conseq							- L. s. (200-2004)		
.O. BOX 0	ires that the death certific signed by the attending p d be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 months? 4 □ Pregnant at time of death 5 □ Other (specify)								23d. Date of delivery Month Day Year		
cords, r	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to c	eath but not res	ulting in the ur	nderlying cause give	en in Part I.		tobacco u Yes 2[he cause of death		
ומו שבכ	n: The law r icete has be r. page 2 sh	Completed							24a. Was auto perf 1 Yes	psy ormed?	prior to co	ppsy findings ava impletion of causi 2 2 No	alable e of	
VISION OF VIC	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate	28a. Date (Mor		ER/Outpatien 28b. Time of Injury	28c. Injun Worl	er: 4 🗆 Nurs	ing Home 5 🔯 Res 28d. Describe	idence 6		(y)		
N N	tel or Atters after de la Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Local City of Suicide 38f. L									al Route Number,	:	
	the Hosp in 24 hou the Funei pletely fil	edical	29a. Certifier 1 (Check only one) Check only 2 Medical Example 1	aminer: On the t	e best of my kno pasis of examina oner stated.	wledge, death tion and/or inv	occurred at the time time of the stigation, in my of	ne, date and pointion, death	place, and due to the occurred at the time,	cause(s) date and	and manner as s place, and due t	itated. the cause(s)		
	T with	Σ	29b. Signature and title of certifier	-/2	2-10	lo	29c. License	number 50209			signed (Month,			
			30. Name and address of person who				,	ve Ga	ithersbu					
þ	Sta Registr		31. Date filed (Month, Day, Year)		egistrar's Signa		elle							

	. <u></u>		1 - State Registrar	ate of Maryland		artment of			R	ng. No.	106			
	Physici	an	1. Decedent's Name (First, Middle, Last)						Date of Deat Month	Day	Year			
	/Medic	al		HOWARD		4h Cihi Taura	as Lagation		Mar	1		12:45	AM	
	Examin	er	4a. Facility Name (If not institution, give stree			4b. City, Town River		or Death			. 1	oorgo		
_	Funeral		Cresent City Cen 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea	ar If Under	24 Hrs. 8. I	Date of Birth					
	Director		577-20-9160 ¹□M	^{2⊠F} 85	Yrs.	Months Day	s Hours	Min. NC	0 0 0 0 0 0 0 0 0 0	, 192	0 Vij	ginia		
	pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation					1	Od. Inside City I	Limits	
	Aaryla f •ho	ច	DC	1	ashir									
	28e-	rect	10e. Street and Number			101. Zip Code)		1	0g. Citize	n of What Cou	ntry?		
	h with	ai D	4651 Nannie Bu	rroughs Av	e.,NI	E 2	20019			U	.S.A.			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itama 23a or 28e-f ehow important: If Item 27 is marked other then "natural", or Itama 23a or 28e-f ehow injury or other traumatic event, the Medical Examinar must be notified at Once.	by Funeral Director	Never Married 2 Married 1	Nas Decedent Ever in U. Armed Forces? Yes XXNo Yes, Give Year or Dates:		Was Decedent of Yes, specify Co			Yes or No- an, etc.)		3. Time of Death 7, 2006 12:45 AM c. County of Death Prince George 9. Birthplace (State or Foreign Country) 920 Virginia 10d. Inside City Limits Notes and Death Press 2 No Sitizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black Kind of Business/Industry S. Government In Surname) Inson For Yown, State, Zip Code) In NJ 08046 Location - City or Town, State iladelphia, PA ERAL HOME, P.A. Rockville, MD Approximate Batween Onset and Death Onset and Death Onset and Death Onset and Death Interval Between Onset and Death Onset and Death Onset and Death Interval Between Onset and Death Interval Between Onset and Death Onset and Death Interval Between Onset and Death Onset and Death Interval Between Onset and Death Onset and Death Interval Between Onset and Death			
ğ	2 hou	ted	15. Decedent's Educatio (Specify only highest grade cor	n majatadi		ient's Usual Occ kind of work don		t of working		16b. Kind	of Business/In	dustry		
2	thin 7	Completed		College (1-4or 5+)	life.	DO NOT use reti	red)	st or working						
7	Hed w Hygien her th	Co	8th 17. Father's Name (First, Middle, Last)			Clerk	19 Moth	ode Namo <i>(Ei</i>				rnment		
anc	d be findal H	Be	Richard Howa	rđ			18. MOLINE	Lilli			•			
Maryland 21215-0036	should nd Me mark	2	19a. Informant's Name/Relationship (Type, F		19b. Mailir	ng Address (Stre	et and Numbe	er or Rural Ro	oute Number	City or T	own, State, Zip	Code)		
	alth a alth a 27 is		Rowald Stanard (1	•		oledo I		Willi	ngbo	ro,	NJ 0	3046		
ore	of He of He f Item r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Remo	20b. P	lace of Dispo	sition (Name of natory or other p	nace)	Date		20c. Loca	tion - City or To	own, State		
Ĕ	Pag Iment Iant: I		4 ☐ Doylation 5 ☐ Other (Specify)	Che										
Baltimore,	permit Depar Impor eny in		21. Signature of Funeral Service Librage 23a. Part1. Enter the disease, or complication	Swand	4							le, MD		
	The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the extending physicien end The law requires that the death contact that the law requirement of the law requirement	dicai Examiner	shock, or heart failure. List only one call mmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last d	Adenocar Due to (or as a consequence to (or as a cons	uence of):	na of I	Lung V	with M	letas	tase	S	Onset and Dea	ath	
P.O. Box 6	that the death certifica led by the ettending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X No 9 □ Unknown	псу						ar				
	quires that n signed b uld be deta	by	Part II. Other significant conditions contribu	uting to death but not resu	alting in the u	nderlying cause	given in Part i	l.						
Division of Vital Records,	The law requirete late has been si page 2 should	Completed							24a. Was a autops perform	ned?	prior to co death?	mpletion of caus	ariable se of	
/ita	Physician: rthis certifice ral director, p	Be	25. Was case referred to medical examiner?	ieal.		1,		e of Death (C	heck only on	Θ)				
6	Physic this c	5	1 ☐ Yes 2 ☐ No Hospi 27. Manner of Death 28	1 Inpatient 2	ER/Outpatier 28b. Time of	I 3 DOA						(y)		
O	ding h. After fune	tion	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	8a. Date of Injury (Month, Day Year)	Injury	l v	Vork? □Yes 2□		. Describe m	ow injury c				
Divisi	l or Attending effer death. Director: After i in by the fune	Certification:	3 ⊆ Suicido 6 ☐ Could not be —	8e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office	ce ce	28f.	28f. Location (Street and Number or Rural Route Ni City or Town, State)				τ,	
	To the Hospital or Attanding Physiclan: The law within 24 hours effer death. To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	edical C	(Check only 2 Medical Exeminer:	n: To the best of my kno On the basis of examinal and manner stated.	wledge, deat tion and/or in	n occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, and ath occurred a	due to the cat the time, d	ause(s) ar ate and p	nd manner as s ace, and due t	tated. o the cause(s)		
	To th To th compl	Me	29b. Signature and title of certifier	0)		ense number		2					
	9		Jan a	nlev-	V	D	01852			Ma	r. 20	, 2006		
_			30. Name and address of person who complete Paul A. Devore,	M.D. 420	03 Qu	eensbu:	ry Rd	., Нуа	attsv	ille	, MD	20781		
Š	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 2 2006	37 Registrar's Signa	ture	uli								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 MARCH 16, 10:10 A^M HUMPHREY ALTON MARTE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES 6824 FURMAN PARKWAY RIVERDALE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 □ M 2X F SEPT.15,1920 **GEORGIA** Director 289-20-0258 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 ehow amy injury or other treumatic event, the Medical Examinar must be notified at any injury or other treumatic. 28a-f ehow 1 XYes 2 □ No Director PRINCE GEORGES RIVERDALE MD. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20737 U.S.A. 6824 FURMAN PARKWAY Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 □ Divorced BLACK Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED SALES LADY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HATTIE HOOD **GATES** 2 MACK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7509 SHELOWOOD RD., PIKESVILLE, MD. 21208 VALERIA DIZARD/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3-18-2006 RIVERDALE, MD. CHAMBERS CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A - Chamberen MO0091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has funeral director, page 2 2 **X** No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No safter death.
I Director: Aid in by the fu 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a npletely filled 1 🗶 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signative and title of certifier OWO D0034603 MARCH 17, 2006 20 an

State Registrar

Α. 31. Date filed (Month, Day, Year) MAR 2 2 2006

DUAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1800 GOOD LUCK RD. SUITE 401, LANHAM, MD. 20706 DRAKES, M.D. 32 Registrar's Signature

Physician /Medical Examiner

Physician

/Medical

Director

Funerai

þ

Completed

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "neturel", or Items 23e or 28s-1 ehow any injury or other traumatic event, If a Marical Examinational be notified at once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

ed by the attending physician and detached for use as the burial-transit Physician/Medical

Completed by

Be

ို

Medical

Examiner

in the past 12 months? ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Y

23e. Did tobacco use contribute to the cause of death? No 1 Yes 3 Probably 4 Unknown

25. Was case referred to medical examiner? 2 No

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

24a. Was an autopsy 25 No 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 21 No 1 Tyes

27. Manner of Death

28b. Time of

28c. Injury at Work? 1 Tyes 2 No

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

COR

29c. License number DOU41131

3

State Registrar 31. Date filed (Month Day, Year)

DHMH 17 Rev 1/2001

within 24 hours a To the Funeral L To the Hospitel

ORIGINAL

of Vital Records, P.O. Box 68760 HESS JR, RALPH CARBAUGH

1 Tes

1 Natural 2 Accident

3 Suicide 4 Homicide

5 Pending investigation

determined.

6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

he

PECES

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Nursing Home

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

5 Residence 6 Other (Specify)

29d. Date signed (Month, Day, Year)

1124 Opal Court Hagerstown, and

			1 - For Stata Registrar	State of M	larylar				lealth ar Death	nd Ment		ene	06	10599		
			1. Decedent's Name (First, Middle, La	st)	~						ate of Death		V-	3. Time of Death		
	Physici		ADELE MARIE SC	HORMAN HI	JGHES					1	onth rch	Day 17	2006	1:00 P M		
	/Medic Examin		4a. Facility Name (If not institution, giv				4b. City	, Town, or	Location of				unty of Death			
п			Manor Care - Po	tomac			P	otoma	.c			Мо	ntgome	rv		
	Funeral		Social Security Number 6. S		ge (In yrs.	last birthday)		r 1 Year	If Under 24		te of Birth			place (State or Foreign intry)		
	Director		157.03.7448	□M 2 ⊠ F	86	Yrs.	Months	Days	Hours		fonth, Day, 1		9 Camd	en, N.J.		
	9		Usual Residence of Decedent				1									
	urylar show		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits		
	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 ehow important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 ehow any july or other traumatic event, its Medical Examinant until a notified at once.	cto	Maryland Montgome	ery	Da	rnesto	wn						1X Yes 2 No			
	it e	Olre	10e. Street and Number				10f. Z	p Code			10	g. Citizer	of What Cou	intry?		
	23a	La La	16111 Germantown	Road			2	0874				U.S.	Α.			
	tem tem	ne	11. Marital Status	12. Was Decedent Armed Forces		J.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et				es or No- etc.)	14.	ican Indian, , etc.			
36	or I	Ϋ́F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2X If Yes, Give	No	1			Specify:			Se	ecify: Whi			
8	hour ural	D D		Year or Dates:		1 10- 0										
갼	172 mg/mg/	lete	15. Decedent's Education (Specify only highest gradual)			(Give	edent's Usual Occupation se kind of work done during most of working DO NOT use retired)				16	5b. Kind	of Business/ir	ndustry		
12	withii than	Maryland Montgomery Darnestown										ostio				
5	Hygi Hygi ther int,															
an	d be ontal															
<u>-</u>	mark matt	ř	19a. Informant's Name/Relationship (s (Street s					own, State, Zi	n Code)						
æ ≥	d 2 s th ar th ar trau		Nannette M. King											nd 20874		
a)	Hee Hee	13	20a. Method of Disposition	6	20b. F	Place of Dispo	sition (Na	me of		Date	40000		ion - City or T			
ē	Signal Signal	1	1 ☑ Burial 2 ☐ Cremation 3 ☐			cemetery, crer te of H				/22/20	1		r Spri			
Baltimore, Maryland 21215-0036	it. P	6.3	4 Donation 5 Other (Specifical Service Lice)		100.											
Ba Ba	Dep. Imp.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, 11800 New Hampshire Ave, Silver Spring, MD 2													
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failured. List only Immediate Cal. Final disease or condition resulting in death)	Pneumon	ia		ter the mo	de of dyin	g, such as ca	ardiac or resp	uratory arres	t,		Approximate Interval Between Onset and Death Days		
	Examiner			Due to (or as										and the same of		
		-	Sequentially list conditions,	b. Hyperte										Years		
	ted rsit	ulu	cause. Enter Underlying Cause (Disease or injury	Osteopo										V		
	xecu and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as										Years		
8760,	cate be executed physicien and the burial-transit	cal E		d												
189	ficate p phy is the			. d	-											
Вох	at the death certificate be executed by the ettending physicien and teched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Feta	al death 3	∃Ectopic p ∃Other (s	oregnancy pecify)			-	23d	. Date of deliv Month	very Day Year		
P. 0	The law requires that the ste has been signed by the page 2 should be deteche	Ph	Part II. Other significant conditions of	contributing to death I	but not res	sulting in the u	nderlying	called dive	an in Part I	2	3a Did toba	000 1160	contribute to t	the cause of death?		
Records,	signed be de	1 by	,	g to 202		anning in the di	naony ing	cause give	317 W 1 1 LACE 1.					bably 4 X Unknown		
Ö	w require	Completed								_	-	201	0 0 0 1 10	Bubly + Elouviloum		
ec Sec	elaw hast	dr.								2	4a. Was an autopsy		prior to co	opsy findings available ompletion of cause of		
<u>=</u>	r. Th									1	performe □ Yes 21		death?	2 🗆 No		
<u> </u>	iclar sertif ector	Be	25. Was case referred to medical examiner?	Hospital:						of Death (Che	ck only one					
ot o	Phys this al dir	J.	1 ☐ Yes 2 ☒ No	i 🗀 inpati		ER/Outpatier			+ M IAUL2				Other (Speci	fy)		
2	ding Physician: The h. After this certificete ha funeral director, page	o	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year)	28b. Time of Injury		28c. Injury Work			escribe how	r injury o	ccurred			
Division of Vital	at or:	Certification:	2 Accident Investigation 3 Suicide 6 Could not b		* A. C.	1	М		Yes 2 □ No							
<u>≥</u>	or A offer Direction by	in in	4 Homicide determined	28e. Place of In building, e	tc. <i>(Speci</i>	ome, tarm, str fy)	reet, facto	ry, office		28f. LC	ity or Town,	et and N State)	umber or Run	al Route Number,		
_	To the Hospital or Atti within 24 hours efter de To the Funerel Directi completely filled in by ti		29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam	ysician: To the best niner: On the basis	t of my kno	owledge, deatl	h occurre	d at the tim	e, date and	place, and du	e to the cau	se(s) and	d manner as	stated.		
	To the h within 24 To the F complete	Medical	One)	and manner s	tated.											
	S viti	2	29b. Signature and title of cenifier				29	c. License					igned (Month,			
	Q		1 704	auri	.)			D-35	/92		M	arch	20, 2	0, 2006		
	0		30. Name and address of person who				,									
			Swaroop G. Rao, 1				n Dri	ve,	Suite	<i>#</i> 504,	Rockv	ille	, MD 2	0852		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 1	32. Re gist	rar's Signa	ature	parle	,								

			For State Registrar	State	of Marylar		artment of H			iene	10600	
			1. Decedent's Name (First, Midd	le, Last)					2. Date of Deat	th	3. Time of Death	
	Physici		Marion	Anna	Hasper	`t			March 2	0, 2006	6:41 A M	
	/Medic Examin		4a. Facility Name (If not institutio	n, give street and n	umber)		4b. City, Town, or	Location of Death	1	4c. County o	Death	
			15380 Homeland	Drive			Hughes	ville		Char	rles	
	Funeral Director		5. Social Security Number 214-03-3765	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 11,	1918	9. Birthplace (State or Foreign Country) Mary land	
	D		Usual Residence of Decedent			* T 1			may 119	1310		
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or iteme 23a or 28a-f ehow event, the Medical Examiner must be notified at	ō	Maryland Char		10c. Ci	ty, Town or Lo	sville				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	28a-	ect	10e. Street and Number	162		nugne	10f. Zip Code		1	0g. Citizen of Wh	nat Country?	
	Mith Ba or	ā	15380 Homeland	Drive			206	37		U.S.A	,	
	me 2%	Funeral Director	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-	14. Race	- American Indian,	
9	or its	F	1 Never Married 2 Mar	ried 1 Yes	2 🔯 No	1			o Hican, etc.)		White, etc.	
21215-0036	ural',	d by	3 X Widowed 4 □ Divorced		Dates:		1 ☐ Yes 2X ☐ No	Specify:		Specify:	White	
5-(nett	ete		nt's Education est grade completed	1)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wor	king	16b. Kind of Bus	iness/Industry	
12	withir ene. then	Completed	Elementary/Secondary (0-12)	College 1	(1-4or 5+)		omemaker	7		Home 0	wner	
0 0	filed Hygi sther	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, M										
Maryland	hould be ad Mental marked of matic eve	To B	<u> </u>									
ary	and N		19a. Informant's Name/Relations			19b. Maili	ng Address (Street a				tate, Zip Code)	
	s 1 and 2 should if Health and Men Item 27 le marke other traumatic		David J. Haspe	rt / Son							ryland 20637	
Baltimore,	it. Page rtment c rtent: if njury or		20a. Method of Disposition 1 Burial 2 □ Cremation		ii State		osition (Name of matory or other plac	1110010	h 24,		ity or Town, State	
ΕË			4 □ Donation 5 □ Other (5 21. Signature of Funeral Service		St.		S Church 2. Name and Addres				m, Maryland	
Ba	Depa Impo eny Il		John Hyd	20 MOIS	391		untt Fune				ngton Road orf, MD 20604	
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	caused the dear						Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition		is mai	A.as	THERU	SCLC	RUSIS.		Onset and Death	
	/Medical Examiner		resulting in death)	Due to	o (or as a consec	quence of):	1	-, (%)			0 1/	
	ZXXIIII	-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		O (or as a consec		136CVIE	Brs. C	Ista As	E	* More of P	
	ate be executed hysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			Contract of the Contract of th	KILAT	ronj.			Cronges	
oʻ	te be executed ysician and e burial-transit		resulting in death) Last	Due to	o (or as a consec	quence of):	_				, 9	
09289	cate be ohysici the bu	dicai		d. D	EB-Bu	71860	Mous	11/13.			* years	
9 x	ding p	/Me	IF FEMALE:	23c. If ves. c	utcome of pregn	ancv				23d. Date		
Box	death certificate L e attending physic id for use as the b	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live	birth 2 Feta	al déath 3	Ectopic pregnancy Other (specify)			Mont Mont		
P.O.	that the de ned by the a detached f	Physician/Med	9 🗆 Unknown	9□ Unk	nown							
	e jo	۵	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tol	V.	bute to the cause of death?	
Records,	> 11 0	iete							24a. Was a		ere autopsy findings available	
Re	The lav	Completed							autops perform	ned? de	or to completion of cause of ath? ∃Yes 2□ No	
Vital	Physiclan: The rithis certificate harral director, page	Be (25. Was case referred to medica examiner?						th (Check only on			
7	hysi this c	ဥ	1 ☐ Yes 25 No			ER/Outpatier		T I I I I I I I I I I I I I I I I I I I		ence 6 Other		
UQ O	9 ag	tion:	27. Manner of Death 1 Natural 5 ☐ Pendi		e of Injury onth, Day Year)	28b. Time o Injury	Worl	/at k? Yes 2 ⊡No	28d. Describe ho	ow injury occurre	d	
Division of	Attending r death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Plac	ce of Injury - At h	ome, farm, st	reet, factory, office				or Rural Route Number,	
ā	ital or irs afte ral Diri	Certification:	4 Homicide	Duil	ding, etc. (Speci	ny) 			City or Town	n, State)		
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edicai	29a. Certifier Certifyi (Check only one)	ng Physicien: To the Examiner: On the and ma	he best of my kno basis of examina inner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and man ate and place, ar	ner as stated. Indidue to the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certific	ar /	M		29c. License	e number	2	9d. Date signed	(Month, Day, Year)	
}	1.7		Jun 1	Shalo	7/1/	W	I D	2060	19	3/	20 06.	
	EL		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type:	rint)	1.1.	22 0 200	Vr. M	SUSCOS	
ye.	Sta	te	31. Date filed (Month, Day, Year	32/	Aegistrar's Sign	ature	0111	· VVI	a C 13 (1)		2.000	
-4	Registr		31. Date filed (Month, Day, Year	1 2006	Registrar's Sign		000					

		ľ	1 - For State Registrer	itate of Mar	yland / Depa <i>Cei</i>	artment of rtificate of		-	giene Reg. No. 006	0601			
	Physici		Decedent's Name (First, Middle, Last) JOHN CHARLES HUMPHE	EYS III				2. Date of De MARCH	ath 18, Day 2006 Year	3. Time of Death 08:10 A M			
	/Medic Examin		4a. Facility Name (If not institution, give stree CHESTER RIVER HOSP)		ER		or Location of Deat STERTOWN	h	4c. County of Death KENT				
	Funeral Director		177-01-2075	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Yea Months Day		8. Date of Bir AUGUS T	9. Birth (28°, 1913) 9. Birth	place (State or Foreign ntry) CHINA			
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD QUEEN AND		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 X No			
	with the ? 3a or 28a-	I Director	10e. Street and Number 106 SECOR ROAD			10f. Zip Code 2162			10g. Citizen of What Cou USA	ntry?			
920	be filed within 72 hours after death with the Maryland tial Hygiene. dother than "natural", or Itams 23a or 28a-f show evant, the Medical Eria" in writinal be routh of a	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1	Was Decedent of f Yes, specify Cu 1 ☐ Yes 2 ☒ N	Black, White	14. Race - American Indian, Black, White, etc. Specify: WHITE					
Maryland 21215-0036		Completed	15. Decedent's Educat (Specify only highest grade c		(Give	dent's Usual Occ kind of work don DO NOT use retii GINEER	e during most of wo	rking	16b. Kind of Business/lr				
land ;	e d at a g	To Be C	17. Father's Name (First, Middle, Last) JOHN CHARLES HUMPHI	, Maiden Sumame) NER	-								
, Mary	s 1 and of Health itam 27 othar ti		19a. Informant's Name/Relationship (Type, EDALINE M. HUMPHRE)				ot and Number or ReDAD, CHEST		er, City or Town, State, Zi MD 21620	c Code)			
Baltimore,			20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify)	oval from State	CHESAPEAK	natory or other p E CREMAT	$10N \mid 03/2$	Date 20/2006	20c. Location - City or T	E, MD			
Balt	permit. Departr Imports any inji	Chan Jilliam 130 SPEER ROAD, CHESTERTOWN, FID 210											
	Physician /Medical	resulting in death)											
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	`	consequence of):								
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a o	consequence of):								
O. Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□Unknown	Fetal death 3	Ectopic pregnar Other (specify)	icy		23d. Date of deliv Month	ery Day Year			
0	w requires that been signed b should be deta	by	Part in Other significant conditions centri	buting to death but	1/ .	nderlying cau	iven in Part I.	23e. Did t	obacco use contribute to Yes 2□No 3□Pro	\ /			
Vital Records,	(0	Completed						1 Tes	prior to condeath? 2 No 1 Yes	opsy findings available ompletion of cause of			
of	Physic this ce al direc	To Be	THES ZYING	pital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day)		t 3L DOA	ther: 4 Nursing I	1	one) dence 6 ⊡Other (Speci how injury occurred	fy)			
Division	To tha Hospital or Attanding I within 24 hours after death. To tha Funaral Director: After completely filled in by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		r - At home, farm, str	M 1	☐Yes 2☐No	28f. Location (Street and Number or Rur wn, State)	al Route Number,			
	Hospital of the policy of the	Medicai Ce	29a. Certifier (Check only one) 2 Medical Examine	an: To the best of and manner state	xamination and/or in	n occurred at the vestigation, in my	time, date and place	e, and due to the arred at the time,	cause(s) and manner as s date and place, and due t	stated. o the cause(s)			
.	To tha within 2 To tha complet	Mec	29b. Signature and title of certifier	and mariner state	~ 0	29c. Lice	nse number		29d. Date signed (Month,	Day, Year)			
7)	ms		30. Name and address of person who com	eleted cause of dea	th (Item 23a) (Type,	Prin LQ	sterdo	in A	12/	020			
:	Sta Registr		31. Date fied (Month, Day, Year) MAR 2 0 2	32. Register	s Signature	South							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month March 16, 2006 Louise S. Jaeger 8:15 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5802 Nicholson Lane Apt.# 906 Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 20, 1931 9. Birthplace (State or Foreign Country) Mississippi 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 458-46-9251 74 Yrs Director Usual Residence of Decedent the Manyland 10a. State 10b. Count 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Directo Maryland Montgomery Rockville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5802 Nicholson Lane Apt. #906 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 Caucasian 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hiram Sessions Louise Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Jaeger / Son Anchorage, AK 99508 P.O.Box 210231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 3/24/2006 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike; Rockville, Maryland 20852 23a. Part1. Enjer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Sarcoma 6 months /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medicai 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy igned by the atte in the past 12 months? 1 ☐ Yes 2 🖾 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Non Insulin dependent Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Was an Chronic Lymphocytic Leukemia 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 2X No Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death Check onlone Other: 4 Nursing Home 5X Residence 6 Other (Specify, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 ☐ Yes 2 🔀 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 XNatural death. 1 Yes 2 No 2 Accident after death the 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospitel o within 24 hours aft To the Funerei Di 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier edical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D50030 March 20,2006 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David Rogers, M.D. 5530 Wisconsin Ave. #1400, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) MAR 22 32. Pegistrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** JASPER Sr COOLIDGE HARDING 11:05P M March 13, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Potomac Valley Nursing Home If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Aug. 21,1923 Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □**N**M 2 □ F Yrs. Virginia 82 Director 228-40-1746 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Madison Criglersville 77 A or 28a-1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 22727 88 Elementary Acres 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Black ō Baltimore, Maryland 21215-0036 1 ☐ Yes 🌪 ☐ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Farmer Self-employed 5_{th} 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nd 2 should be fil lith and Mental H 27 le marked ott r traumatic even permit. Pages 1 and 2 should be Department of Health and Mental Important: If tam 27 Is marked eny Injury or other traumatic evone. George W. Jasper Maria Twyman ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) v² 2727 88 Elementary Acres, Criglersville, Sarah E. Jasper (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gordon Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3-18-06 Madison, VA 4 □ Donation 5 □ Other (Specify) Snowden Funeral Home 21. Signature of Euneral Service Lic 22. Name and Address of Facility 246 N. Washington St Rockville, MD 20850 23a. Part1. Enter the disease or complications that caused the death. D shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a prisequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physiclen and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FFMALE . If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records. à page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 □ FR/Outpatient 3 □ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manger of Death Certification: Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and Little of certifier D0062435 e of death (Item 23a) (Type-Print) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 22 MAR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amended item 10c per fh/wich@rtificate of Death_3_21_06/dls Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 08:15 Margaret Johnson 03 ٥٥٩ /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Wicomico Center Deer's Head Hospital 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 F 8 5 Yrs. 218 -28-02/p 11/21/1947 Director Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic avant, it is Modical Examinar must be notified at 1 XYes 2 ☐ No Parsonsburg ML WICOMIC Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 5 A Grove Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status t Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: by 3 ☐ Widowed 4 ☐ Divorced 2/AC Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DINT 12 if Health and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be HN dre IAM MANIE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21849 PARSONS DUT Ster Forest Grace Kd 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. L. carion - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of the Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 Removal from State 3 4 □ Donation 5 □ Other (Specify) Green Heres 06 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gennie Smith 917W ISAbell Jalis tunenal Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximat Interval Between Onset and Death Immediate Cause (Final disease or condition Renal End stage **Physician** eur /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or irriury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?
1 Yes 2 No
9 Unknown detached for 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 3 Probably 4 Noknown 1 ☐ Yes 2 ☐ No Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an Melizta After this certificate has autopsy performed? 1 ☐ Yes 2 No page 2**X** No Frotillation Atrial 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: Hospital: 1 ☐ Yes 2 X No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3 DOA Medical Certification: To 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) Manner of Death

Natural

Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending 1 ☐ Yes 2 ☐ No death. investigation the Diractor: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

filled in by hours after within 24 hours a To the Funeral L Hospitel completely the

Registrar

31. Date filed (Month, Day, Year) MAR 2 1 2006

10009

Hend

(Check only one)

29b. Signature and title of certifier

30. Name and address of person,

Deerly

32. Registrar's Signature

staff

who completed cause of death (Item 23a) (Type, Print)

Physician

29c. License number

006

29d. Date signed (Month, Day, Year)

119/2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2006 6:10P M MARCH GERTRUDE **JENKINS** EDITH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY CUMBERLAND CUMBERLAND NURSING HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV • 21, 1909 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 96 1 □ M 2 🕅 F 007-10-7427 CANADA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28e-f show traumatic event, the Medical Examiner must be nultified at 1 Yes 2 No CUMBERLAND ALLEGANY Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21502 31508 MOORE'S HOLLOW ROAD Items 23e death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. filed within 72 hours after ☐ Yes 2 🛣 No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: "naturei", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) RETAIL STORE SALES CLERK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) perriit, Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth any july or other traumatic event once. Be VAN WART MAHALA ELIZABETH SMITH HARRY GRAY ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10103 TOWN CREEK ROAD, N.E., FLINTSTONE, MD 21520 JEANNE EATON / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SUNSET MEMORIAL PARK 03/15/2006 CUMBERLAND, MD ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the ofsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Spination Physician disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 nonths?
1 Yes No 3 Ectopic pregnancy Day j 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part #: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 1 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier U 71/2 32. Registrar's Signature Registrar

			1 - For State Registrar	State of Ma	•		t of H	leaith a		ental Hy	giene	006	1060	36	
			Registrar 1. Decedent's Name (First, Middle, Las	at)		Jeruncau	e or t	Jealli		2. Date of De	Reg. No.		3. Time of	Death	
, X	Physici	_		/						Month March	Day	006	5:30	A M	
	/Medic		Maggie Bell Jones 4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of		TIGIT CIT		County of Death			
*	LAGITI		8201 16th Street	Apt. 204		Silv	Silver Spring					Montgomery			
6.	Funeral Director		423-34-3919	ex 7. Age ☐ M 2[X] F	e (In yrs. last birth 80 Yı	day) If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 07/24/	th 1 <i>y, Year)</i> 1925		nplace (State or untry) bama	Foreign	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						1	10d. Inside Cit	y Limits	
	Many f sho	ō	Maryland Montgom	erv	Silver	Spring							™ Yes	2 🗌 No	
	h the	irec	10e. Street and Number			10f. Zip	Code				10g. Citize	en of What Cor	untry?		
	23a c	ai D	8201 16th Street	Apt. 204		209					USA				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatith and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show stry injury or other traumatic event, the Medical Examinar must be notified at an ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ ↑ If Yes, Give Year or Dates:		13. Was Deced If Yes, spec		ispanic Orig in, Mexican, Specify:	in? (Spec , Puerto R	rify Yes or No lican, etc.)	o- 14. Race - American Indian, Black, White, etc. Specify: Black				
Maryland 21215-0036	2 hou	ted	15. Decedent's Ed		16a. C	Decedent's Usua	al Occupa	ation	of workin	7	16b. Kind	d of Business/l			
215	ithin 7 99.	Completed	(Specify only highest gra	College (1-4or 5	i+)	Give kind of wo life. DO NOT u	se retired	dring most	OF WORKIN	g					
2	tygier ther th		10 17. Father's Name (First, Middle, Last)		Die	tary Ai	lde	10 Matha	r'o Namo	(First, Middle		ing Ho	me		
anc	d be findal H	Be										umame)			
Ž	should nd Me mark matic	은	Henry Washington 19a. Informant's Name/Relationship (Type, Print)	19b. I	Mailing Address	(Street a			Roger		Town, State, Z	lip Code)		
	nd 2 : alth ar 27 le		Denise C. Jones/			5 Lytto								20910	
Baltimore,	Pages 1 a ent of Her nt: If item ry or othe		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)		20b. Place of D cemetery,	Disposition (Nar., crematory or o	ne of ther plac	e)	Da	ite	20c. Loca	ation - City or I			
Balti	permit. Departmitmporta		21. Signature of Funeral Service Licer	2	, indirect	22. Name an	d Addres	ss of Facility	Robe	rt E.	Evans		al Home		
3760,	Physician /Medical Examiner but suits private per executed by suits that suits the private pri	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as	of the P a consequence of a consequence of):	3						Onset and D	realin .	
.O. Box 68	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)					23d. Date of delivery Month Day Year					
a	Se us	ρ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in t	the underlying o	ause give	en in Part I.					the cause of de		
of Vital Records,	: The law require cate has been si page 2 should I	ompleted								24a. Was		24b. Were au prior to death?	topsy findings a completion of ca	available ause of	
a		e Co	25. Was case referred to medical					OG Place	of Dooth	1 Yes		1 🗆 Yes	2 No		
₹	Physician: this certific ral director,	To B	examiner?	Hospital:	ent 2 🗆 ER/Outp	patient 3 DC	Oth	0.0		(Check only		Other (Spec	ofu)		
ion of	ding After fune	ertification; T	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ry 28b. Tii		8c. Injury		2	8d. Describe			<i></i>		
Division	e a si si si	Certific	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farr c. (Specify)	n, street, factory	, office		2	8f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Numb	ber,	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best niner: On the basis of and manner sta	fexamination and	death occurred for investigation	at the tim , in my of	ne, date and pinion, deat	d place, a th occurre	nd due to the d at the time,	cause(s) a date and p	ind manner as place, and due	stated. to the cause(s)		
)	To t To t	Σ	29b. Signature and title of certifier			290		e number 004588	31			signed (Month)			
			30. Name and address of person who Dr. Carl Johnson	concleted cause of d			ırgo,	, MD	2077	4					
	Sta Registi		31. Date filed (Month, Day, Year)		ar's Signature	book									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Month Year **Physician** 2006 Mary Ellen Jenkins /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner in Reltimonia Wishington Merical Cunter 2 Cum Anni If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex **Funeral** Months 1 □ M 2X□ F 220-16-8362 Director Mar 2, 1920 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28a-f show other treumatic event, the Medical Evan in er must be netitived at 1 ☐Yes 2 X No **Owings** Director MD Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20736 U.S.A 879 Fowler Road Items 23e Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married Married 2X No ö 1 ☐ Yes 2X No Specify Specify: Black 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Someone Else's Home Domestic 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental F Alice Chase Charles Coates ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 307 Owings, MD 20736 nt of Health at: If item 27 is Daughter Queenie Coleman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any injury or 03/20/06 Huntingtown, MD 4 □ Donation 5 □ Other (Specify) Patuxent UM Church Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Sewell Funeral Home ewell 4. 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as uence of) 6 Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-transit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 Month Day Year in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an

Priysician Examiner

Baltimore, Maryland 21215-0036

Box 68760. P.0. Records, page 2 Vital or Attending Physician: ctor, dir ō Division Director:

Be 2 by

Completed by Physician/Medical Examiner Certification: filled within 24 hours a To the Funerel I 29a, Certifier Medical

25. Was case referred to medical examiner? 2 No 1 🗌 Yes 27. Manner of Death

1 atural 2 Accident 3 Suicide 4 T Homicide

5 Pending investigation 6 Could not be determined

Hospital: 1 Unpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Location (Street and Number or Rural Route Number, City or Town, State)

autopsy performed? Yes 25 No

1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State

BOM 31. Date filed (Month, Day, Year)

2406

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registras Signature

0

Registrar

To the Hospitel

			1 - For State Registrar	State of Ma	ırylan		artmen rtificat			ind M	ental Hy	gien Reg. N	UUb	105	08	
	Discontat		1. Decedent's Name (First, Middle, La	ist)							2. Date of De		ay Year	3. Time	of Death	
	Physici /Medio		BETTY LEONA KERN	IAN							March			6:45	5 р ^м	
	Examir		4a. Facility Name (If not institution, give	re street and number)			4b. City,	Town, or	Location of	f Death		4	c. County of Death			
			Washington Adven									Montgomery				
	Funeral			Sex 7. Age 1□M 2፟XF		ast birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Yea	r) 9. Birth	place (State intry)	or Foreign	
	Director		577-42-0370 Usual Residence of Decedent	221	74	Yrs.					(Month, Da August	21,	1931 Mary	yland		
	and		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits	
	f sho	ō	Morrison d Designation	01-	TD 1										s 2 No	
	28a	Je C	Maryland Prince	George's	ВТS	idensb	urg 10f. Zip	Code				10g. C	itizen of What Cou	intry?		
	3a or	<u> </u>	5003 Quincy Stre	o.t				710					S.A.	, .		
	ms 2	Funeral Director	11. Marital Status	12 Was Decedent F	ver in U.	S. 13. V			spanic Orig	in? (Spe	cify Yes or No Rican, etc.)		14. Race - Ameri	can Indian,		
9	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉 N	0					Puerto F	Rican, etc.)		Black, White	etc.		
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "netural", or Items 23a or 28a-f show with the Medical Examinar must be mailisd at	l by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2 <u>IX</u>) No	Ѕрөслу:				Specify: Wh:	ite		
ည	72 h	Completed	15. Decedent's E (Specify only highest gra			16a. Deced	dent's Usua kind of wo	al Occupa	tion uring most	of working	na	16b.	Kind of Business/Ir	dustry		
7	ithin Jen M	ğ	Elementary/Secondary (0-12)	College (1-4or 5-	+)				uring most		•					
2	led w tygien her ti	S	12			Home	maker		10 11-11-	de Maria	/mi		n Home			
anc	be fill H	Be	17. Father's Name (First, Middle, Last								(First, Middle	, Maide	n Sumame)			
Ž	hould d Me mark matic	ဥ	John Randolph Ba 19a. Informant's Name/Relationship (105 14-15-		(0)	Edna			0"				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural", or Items 23a or 28a-f show any injury or other treumatic event, the Madical Examinat must be notified at ance.		Glenn Kernan - S										or Town, State, Zij		0600	
o,	1 an Heal em 2 em 2		20a. Method of Disposition	Oli	20b. PI	ace of Dispo	sition (Nan	ne of			ate		wn, Maryl		0639	
ē	ages nt of r: # it		1 ☑ Burial 🙎 🗆 Cremation 3 🗆			emetery, cren			- 1	0./0/	10006		•			
Baltimore,	artme arten orten injury		* 4 □ Donation 5 □ Other (Special Service Lice)		Mar	ytand v	eterar	d Address	netery	3/22	2/2006	Ch	eltenham,	Mary.	land	
æ	permi Depa Impo any i		V1 4 5/11	,									ral Home,			
	111		23a. Parl 1. Enter the disease, or com	plications that caused	the death	. Do not ent	er the mod	e of dvina	. such as c	ardiac or	respiratory a	LSV.	ille, MD	Approxima	ate	
	Dhusisian		Immediate Cause (Final	one cause on each lin	e	dis	1 /	1				110		Interval Be Onset and	etween	
	Physician /Medical		disease or condition resulting in death)	a Due to (or as a		iginice of):	JUU	M	MÜ	Ш_	a	yl	0/			
	Examiner			200 10 (01 03 2	CONSEQU	20 9/2	1101	Mal	de	LTN	vm	len	Mansky			
١,		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequ	ience of		oug	40		0010	71	Cilland			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c A	ah	hulo	000	10	11	mo	11 mi	m	U			
o,	a exerian ar	EX	resulting in death) Last	Due to (or as a	consequ	ence of:			170	7-05						
8760,	cate be executed bhysician and the burial-transit	Physician/Medical	•	_ d	/											
9	artifica ing pl	Med	IF FEMALE:							_						
Вох	ath ce ttend or use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1□Live birth			Ectopic pr	egnancy					23d. Date of deliver	ery Day	Year	
<u>.</u>	the a	Sic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at t 9☐Unknown	ime of de	oath 5□	Other (sp.	ecify)					WORK	Day	l eai	
Р. О.	The law requires that the death certific ate has been signed by the atlending p page 2 should be detached for use as	Ph	Part II. Other significant conditions of	contributing to death bu	t nA racu	olting in the	dorhinh o	auco area	n in Part I		23a Did t	obacco	use contribute to t	ha cause of	death?	
ds,	signe d be o	1 by	(mon stal	A south of the sou	K 0/	111	Di	1//1	111					ably 4 🕅	-	
0	w requir been si should	Completed	- Grys rus		W		K	KI	u							
န္တ	elaw has je 2 s	id m					/				24a. Was		24b. Were auto prior to co death?	psy findings mpletion of	available cause of	
a	n: Th licate r, pag										1 Tes	2 🗓 N	o 1 ☐ Yes	2 No		
₹	siciel certii irecto) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 🔀		-5/0					(Check only o					
ō	Phy r this	1; To	27. Manner of Death	1 Inpatier 28a. Date of Injury (Month, Day)		R/Outpatien 28b. Time of		8c. Injury Work	at Nurs		8d. Describe h		6 Other (Specif	y)		
0	nding th. : Afte	tio	1 Natural 5 Pending 2 Accident investigation		Year)	Injury	м		? es 2 □ N			•	,			
Division of Vital Records,	Attending Physicien: r death. ector: After this certifics by the funeral director, t	ifica	3 Suicide 6 Could not b	286. Place of inju	ry - At hor	me, farm, stre	et, factory	, office		2	8f. Location (5	Street a	nd Number or Rura	al Route Nur	nber,	
	s effe	Certification;	4 Notticide	building, etc.	(Ѕреспу)					City or Tov	wn, Stat	re)			
	To the Hospitel or Attending Physicien: The law within 24 hours elter death. To the Funerel Director: Atten this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	nysician: To the best of	f my knov	viedge, death	occurred	at the time	e, date and	place, ar	nd due to the	cause(s	s) and manner as s	tated.		
	the H in 24 the F nplete	ledical	one)	and manner stat	ed.										5)	
	To To	Σ	29b. Signature and title of certifier	-			29c	. License	number	11.	7	29d. Da	ate signed Month,	Day, Year)		
Λ	6							5	6/	4			3/17	106)	
R	(3)		30. Name and address of person who	1-						(/		-/ //			
	Sta	1 0	31. Date filed (Month, Day, Year)	A. C. C. Registra	MD r's Signat	7610	Carro	011 /	venue	#2	205, Ta	kom	a Park, W	D 209	12	
	Sta Registr		MAR 2 1 200	6 Elece	K	ure does	w									

		-	For State Registrar	State of Marylar		artment of Hertificate of L			jiene lag. No.	5	0609
ı	Physicia Physicia	an	Decedent's Name (First, Middle, Last BARBARA ROWARD			-		2. Date of Dea Month	Day 2006	Year	3. Time of Death 1:40 p ^M
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	riai cii i	4c. County		1:40 p
	Examin Funeral Director	er	Hillhaven Nurs 5. Social Security Number 6. Se	ing Home	last birthday) Yrs.	Adelphi If Under 1 Year Months Days		8. Date of Birth (Month, Day June 7	, Year)		orge's lace (State or Foreign nont
	P.		Usual Residence of Decedent	100 0	ty. Town or Lo			*			0d. Inside City Limits
	show	5	10a. State 10b. County		,						1 X Yes 2 No
	28a-f	ect	Maryland Prince Ge 10e. Street and Number	orge's Col	lege P	ark 10f. Zip Code			10g. Citizen of W	Vhat Cour	ntry?
	Mith Sa or	Funeral Director	4805 Guilford Road	1		20740			U.S.A.		,
	death	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp				an Indian,
326	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or items 23a or 28a-f show event. I'm Medical Evenifier must be notified at event.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ፟፟X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	nican, etc.)	Specify	k, White, "Whi	
9500-91212	72 hou	ted	15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Occupa	ation furing most of work	(ina	16b. Kind of Bu	siness/Ind	dustry
Z	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done o DO NOT use retired)	9			
2	should be filed within de Mental Hygiene. marked othar than imatic evant, It at Mental Hygiene.			44	Homen	naker	18. Mother's Nam	o (Circe Adiddle	Own Hon		
and E	0 = 0 %	Be	17. Father's Name (First, Middle, Last)					•		θ)	
Maryland	should ind Men s marke umatic	ဥ	Louis Davidson Roy 19a. Informant's Name/Relationship (T)		19b Mailir	ng Address (Street a	Margaret			State. Zic.	(Code)
<u>8</u>	d 2 si th an th an t7 is r	1 3	Priscilla J. Kelle			Brentlei					
	Heal Heal tam 2		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place		Date	20c. Location -		
ᅙ	Pages nent of int: If it ury or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ I 1 ☐ Donation 5 ☐ Other (Specify,	Removal from State	-	s Cemetery		1/2006	Cheltenh	ıam.	Maryland
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signalure of Purieral S. Vice Lies No.		22	2. Name and Addres	s of Facility Gas	sch's Fu	neral H	ome,	P.A.
	#85 6 C		23a. Parti. Enter the disease, or comp	ligation, that caused the dea						, 110	Approximate
	Physician:	K Q	shock, or heart failure. List only of immediate Cause (Final diseas) if condition resulting in death)	one se on each line. Cardiac Ar:							Interval Between Onset and Death 5 Minutes
	/Medical Examiner		resulting in death)	Due to (or as a conse							
		<u></u>	Sequentially list conditions,	b. Dehydration Due to (or as a conse						-	4 Days
	nsit	nin.	Sequentially list conditions, if any, leading to immediate cause. Enter Judy 19 Cause (Disease or injury	Dysphagia	-					- 1	1 Month
~	execun and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):			•			
68760,	icate be executed physician and s the burial-transit	edical		d. Cerebrovas	cular A	Accident					1 Month
P.O. Box 6	Physician: The law requires that the death certifi this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat Mor	e of delive	ery Day Year
Vital Records, P	uires that signed b	by	Par II. Other significant conditions of Carcinoma Bladder			inderlying cause give	en in Part I.				he cause of death? Dably 4 Unknown
Ö	w requir	Completed	Anemia					24a. Was	an 24b. \	Nere auto	ppsy findings available
Re	The la te has age 2	Juo	Hypertensive Card	iowacoular Di	00300			autop perfor	rmed?	death? I □ Yes	mpletion of cause of
ta	ysician: The lav is certificate has director, page 2	BeC	25. Was case referred to medical	IOVASCUIAI DI	sease		26. Place of Dea	th (Check only o			
<u>=</u>	Physici this cer al direct	To B	examiner? 1 □ Yes 2 📉 No	Hospital: 1 ☐ Inpatient 2 [☐ ER/Outpatie	nt 3 DOA Oth	er: 4 X Nursing H	ome 5 Resid	lence 6 Oth	er (Specil	(y)
on of	ding h. After fune		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	now injury occurr	ed	
Division	or Attan after deat Diractor: in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec		reet, factory, office		28f. Location (S City or Tow		er or Rura	al Route Number,
	To the Hospital or Attanwithin 24 hours after death To the Funaral Director: completely filled in by the	edical C	29a. Certifier 1 X Certifying Ph. (Check only one)	ysician: To the best of my kr ninar: On the basis of examin and manner stated.	nowledge, deat nation and/or in	th occurred at the tin	ne, date and place pinion, death occu	, and due to the orred at the time,	cause(s) and ma date and place,	inner as s and due t	stated. o the cause(s)
	To the within 2 To tha complet	Me	29b. Signature and title of certifie			29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)
}	F 5 F Ö		* (MOBOUL	W		D17	7843		March	17,	2006
0	(5)		30. Name and address of person who								
	0		Vivek C. Vaid, M.			race #B10	02, Hyatt	sville,	MD 2078	32	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 1 2006	A. Registrar's Sign	natura	de					

DHMH 17 Rev 1/2001

			For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artmer ertificat					giene Reg. No	UUD	106	10
			Decedent's Name (First, Middle	e, Last)							2. Date of De	ath		3. Time o	of Death
	Physicia		George Pe	ter	Kalas	s, Sr.					Month March	20 .	y Yeer 2006	2:28	A M
	/Medic Examin		4a. Facility Name (If not institution			,	4b. City	Town, or	Location	of Death			County of Dea		
			Fort Washington	. Hospital			Ft.	Wash	ingt	on		P	rince (Georges	
	Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F		yrs. last birthday) If Unde Months		If Under	A dian	8. Date of Bir (Month, Da	th y, Year)	9. Bir	rthplace (State ountry)	or Foreign
	Director		578-12-5438			83 Yrs.					Februar	y 2/	7,1923 T	vashing	ton,DC
	and	}	Usual Residence of Decedent 10a. State 10b. County		10	c. City, Town or L	ocation							10d. Inside C	ity Limits
	f ahd	ō	Maryland Prince	Georges]	Fort Was	hingt	on						1 □ Yes	2 🔯 No
	the 1	Director	10e. Street and Number		l		10f. Zi	Code	-			10g. Cit	izen of Whal C	ountry?	
	3e or		704 Carnoustie	Lane			2	0744				USA	1		
	death ms 2:	era	11. Marital Status	12. Was Dec	edent Ever	r in U.S. 13.	Was Dece	dent of Hi	ispanic O	rigin? (Spe	ecify Yes or No		14. Race - Am		
0	after or Ita	Funeral	1 Never Married 2 Mar	ried Armed F	2 No	WII	1 ☐ Yes		n, mexica Specify		Rican, etc.)		Black, Whi		
3	ours ral',	d b	3 Widowed 4 □ Divorced	Year or I	Dates:			221110	эрвспу	•			Specify: WII	LUC	
5	72 h "natu	Completed	15. Deceden (Specify only highe	it's Education st grade completed,)	16a. Deci (Giv	edent's Usu e kind of wo DO NOT o	al Occupa ork done o	ation during mo	st of work	ing	16b. K	ind of Business	s/Industry	
1	within sne.	mp	Elementary/Secondary (0-12)	College	(1-4or 5+)		ral D					Se1	f-Emplo	oved	
7	Hygie thar thar		17. Father's Name (First, Middle,	Last)						er's Name	e (First, Middle,				
0	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. Is marked othar than "natural", or Itams 23e or 28a-f ahow umatic avant, if a Maralcal Examilier in the multified at	To Be	Constantinos	Kalavit	tinos				Jenn	ıa		K	Coutroul	bis	
Z Z	shound Mind Mind Mind Mind Mind Mind Mind Mi	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mai	ing Addres	S (Street 2	and Numb	er or Rura	al Route Numbe	er, City o	or Town, State,	Zip Code)	
Ž	and 2 ealth a n 27 is		George P. Kala	as, Jr	Son	211A	King	Geor	rge S	St., .	Annapol	is,	MD 2140	02	
ב ב	Pages 1 and the sent of He int: If itam		20a. Method of Disposition 1XXBurial 2 ☐ Cremation	2 Personal from		20b. Place of Disp cemetery, cre	osition (Na ematory or	me of other plac	e)		Date	20c. Lo	ocation - City or	r Town, Slate	
É	Page nent: It ent: It ury o		'4 □ Donation 5 □ Other (S]	Resurrec	tion	Cemet	tery	Marc	h 24,20	06	Clinton	n, MD	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If itam 27 is marked othar than "natural", or Itams 23e or 28a-f ahow any injury or other traumatic avant. If a Marical Examinet man be notified at once.		21. Signature of Juneral Service	ticensee		Ğ	2. Name a eorge 160. O	P. F	s of Facil Calas	Fund Rd	eral Ho	me,	P.A. MD 20	745	
			23a. Parti. Enter he disease, or shock, or heart failure. List	complications that	caused the								110 20	Approxima Interval Be	te tween
	Physician		Immediate Cause (Final disease or condition	-		c Prosta	te Ca	ncer						Onset and	Death
	/Medical		resulting in death)	u.		onsequence of):	00								
	Examiner		Sequentially list conditions,	b											
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a co	onsequence of):									
	xecut and al-trar	xan	that initiated events resulting in death) Last	c	o (or as a co	onsequence of):						-			
,	icate be executed physician and s the burial-transit	dicai													
=	g phy as the	O I													
5	endin use	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			□Ectopic p	regnancy					23d. Date of de	,	
	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at lim		Other (s			· · · ·	 		Month	Day	Year
_	at the	Phy	9 Unknown Part II. Other significant conditi			nt constitue in the			an in Dort	1	23e Did I	obacco i	use contribute t	to the cause of	doath?
Č Z	ires that the death certif signed by the attending d be detached for use a	by	Coronary Artery	_	death out in	or resulting in the	underlying	ause give	on III Fait	1.			DXNo 3□P		
5	w requir been s should	Completed									24a. Was				
ט	has l	mpi									autor		prior to death?	utopsy findings completion of c	cause of
ō	n: Tr ficate r, pa		O5 Man and referred to medica	1					00 Plan	a of Docati	1 Yes		1 □ Ye	s 2 No	
5	sicial	o Be	25. Was case referred to medica examiner? 1 ☑ Yes 2 ☐ No	Hospital:	Inpatient	2 XER/Outpatie	ort 3 🗆 🗅	Othe	or		h (Check only o		6 □Other (Spe	acifu)	
5	ding Physician: The lav h. After this certificate has funeral director, page 2	\vdash	27. Manner of Dealh	28a. Date	of Injury	28b. Time		28c. Injury Work			28d. Describe			- SCHY)	
5	nding ath. r: Afte e fun	atio	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	19	nth, Day Ye	ear) Injury	М		Yes 2 □]No					
2	r Attander death	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide delem	nined 286. Plac	e of Injury	- At home, farm, s	treet, factor	y, office			28f. Location (nd Number or F	Rural Route Νυπ	nber,
5	ital or rs aft ral Dii	Cer													
	To the Hospital or Attending Physicien: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical		ng Physician: To th Examiner: On the and ma		amination and/or i									s)
	To th within To th comp	Me	29b. Signature and title of certifie	ır				c. License					te signed (Mon	ith, Day, Year)	
	0			7111			ע	1290	0			3/2	20/2006		
_	-(5)		30. Name and address of person Louis V. Kaufi					ntre	#207	7, Wa	ldorf,	MD 2	20602		
j	Sta Registr		31. Date filed (Month, Day, Year, MAR 2 1	2006	Registrar's	Signature do	AL.								

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Marylan		rtment of F			giene) 0 6	10612
	Physici /Medic		1. Decedent's Name (First, Middle, Las	v VU				2. Date of Dea Month MW Ch	th Day Yea (8 26b)	
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea		4c. County of De	eath
	Funeral Director		5. Social Security Number 6. \$4 215-44-9949 Usual Residence of Decedent			If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Birth	, Year)	Birthplace (State or Foreign Country) Maryland
	yland		10a. State 10b. County	10c. City	y, Town or Loca	ation				10d. Inside City Limits
	n the Mar r 28a-f at	Funeral Director	Maryland Freder 10e. Street and Number	ick Fred	lerick	10f. Zip Code		1	0g. Citizen of What	13€ Yes 2 □ No Country?
	23a c	ai D	502 Lee Place			21	1702		United S	tates
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event. The Modical Examiliar must be notified at ODGE.	by	11. Marital Status 1 Never Married 2 知 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Y	as Decedent of H Yes, specify Cuba □ Yes 2 <mark>1</mark> 2 No	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black, W Specify:	merican Indian, hite, etc. hite
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra-		(Give ki	nt's Usual Occup	durina most of we	orking	16b. Kind of Busines	
121	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	O NOT use retired	1) -			
	illed Hygid other	Be Cc	12 17. Father's Name (First, Middle, Last)		Titl	e Abstra		ame (First, Middle, I	Real Est Maiden Surname)	ate
/lan	uld be Menta Irked Itic ev	To B	Chester Elwood Boo	one			Mary El	len Barth	low	
Maryland	2 sho		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing	Address (Street	and Number or F	Rural Route Number	, City or Town, State	o, Zip Code)
	1 and Health em 27	1	Samuel H. Kipe/ Hu 20a Method of Disposition	20b. P	lace of Disposit	tion (Name of			1and 2170 20c. Location - City	
Baltimore,	Pages ent of nt: If it		1⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	emetery, crema	atory or other plac	· 1		0.00	
alti	permit. F Departm Importar Eny injur		21. Signature of Juneral Service Licen	DIU	e Klage	Cemeter Name and Address	s of Facility	ome P. A.	Thurmont,	Maryland
<u> </u>	88 E 88		Jody DU	Upm	162	1 Opossu	ımtown P	ike, Fred	erick, Ma	ryland21702
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that caused the death one dadse on each line.	i. Do not enter	the mode of dyin	g, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death 3 W.C.L.
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	, 0				3 70 0
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Zoldwal Due to (or as a consequ	Jence of):	rhuge		1		
,	ficate be executed physicien and is the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	uence of):			-/		1,1
8760,	ate be nysicie he bur	licai	(d				$\Delta \Box$		
Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3□E	ctopic pregnancy		HEIL.	23d. Date of o	delivery Day Year
P. O.	t the d by the tached	hysi	1 □ Yes 2 □ No 9 ⊠ Unknown	9□ Unknown		Janos (apocay)				
ords, F	w requires that s been signed b should be det	by	Part II. Other significant conditions co	ontributing to death but not resu	ılting in the und	lertying cause give	en in Part I.	23e. Did tob	·/	to the cause of death? Probably 4 Unknown
Division of Vital Records,	The law rate has be page 2 sh	Completed	RIB Fracture					24a. Was a autops perform 1 Yes 2	v prior t	
Zita Zita	Attending Physician: Thir death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		3□ POA Othe	ar-	ath (Check only on		
ō	Phys ar this aral dir	٦. ا	1 √Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3□ DOA 28c. Injun	4 Nursing		once 6 Other (Sp ow injury occurred	pecify)
<u>ö</u>	arth. or: Afte	atio	1 □Natural , 5 □ Pending 2 Accident investigation	040-1100	1100 A	M 1 T	Yes 2 No	Pedes tri	an hit b	W Vehicle
Σį	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify) - L-	1		28f. Location (St		Rural Route Number, 7 PATRICK
	spital ours a neral C	0	29a. Certifier 1☐ Cartifying Phy	ysician: To the best of my know	JTV LL		and place	51, 1	-NESKRICK	-, mp
	To the Hospital or A within 24 hours after To the Funeral Director Director (Index) in the Funeral Director (Index) in by the Funeral Director (Index) in by the Funeral Director (Index) in t	edicai	(Check only 2 Madical Examone)	iner: On the basis of examinate and manner stated.	ion and/or inves	stigation, in my or	oinion, death occ	urred at the time, da	ate and place, and d	ue to the cause(s)
	To ti To ti comp	W	29b. Signature and title of certifier	- 0		29c. License	number	25	9d. Date signed (Mo.	nth, Day, Year)
•	_		1 HOW			P197	189		March 1	3,2006
920	10		Ryan C. MyR	ompleted cause of death (Item	South	- Greek	re Stre	et B	alto, M	D 21201
	Sta Registr	te ar	31. Date filed (Month, Day, Year) MAR 2 2.	2006 32. Refistrar's Signat	Jr A	neve	2.11			

			1 ⊷ For State Registrar		Marylan	-	artmen rtificat					Reg. No.	06	1061	3
	Dhusisi		Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath Day	Year	3. Time of I	Death
	Physici /Medic		Ire	ene Florenc	e Kem	р					March	27	2006	1246	РМ
	Examir		4a. Facility Name (If not institution,	give street and numb	er)				Location of	of Death		4c. Co	unty of Death		
			258 Cat Swamp	Road				kton				. [ecil		
	Funeral			6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da DEC 21,	h y, Year)	9. Birthr	lace (State or	Foreign
	Director		218-26-7739	IUM ZIAIF	76	Yrs.					DEC 21,	1929	Penn	sylvan:	ia
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	ocation						Т,	0d. Inside City	y Limite
	aryla aho	2		_			Joution							1 ☐ Yes	•
	r 28a-f ahow	ecto	Maryland Ceci		E.	lkton	1.24 3					10 011			- 2/1
	death with the Maryland ms 23a or 28a-f ahow	Directo	10e. Street and Number				10f. Zip					•	of What Cour	•	
	s 23a	Funeral	258 Cat Swamp					1921					ted Sta		
	after des or Itams	nue	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Deced If Yes, spec	tent of Hi cify Cuba	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	- 14.	Race - Americ Black, White,		
36	hours after tural', or Ita al Exemin	by F	1 ☐ Never Married 2 ☐ Marrie 3 🖫 Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 If Yes, Give Year or Date	A		1 ☐ Yes	2 X No	Specify:			Sp	ecity: Wh	ite	
5-0036	72 hours after death witt "natural", or Itams 23a or orcal Exerral - r out Los		15. Decedent		95.	160 Dogo	dent's Usua	al Cooun	ntion			16h Kind	of Business/In		
15	P = 0	Completed	(Specify only highest	grade completed)		(Give	kind of wor DO NOT us	rk done d se retired	luring mos	t of work	ring	100. Killa	or Dasinessynt	uustiy	
2121	withi ene. thar	Ę,	Elementary/Secondary (0-12)	Coilege (1-4	or 5+)		memak		,			In H	er Own	Home	
	e filed within at Hygiene. other then 'vent, the Ma	ပိ	17. Father's Name (First, Middle, L	.ast)					18. Mothe	er's Nam	e (First, Middle,	Maiden Su	mame)		
an	d be antai	00	Thomas Dempsey	7					The	ılma	Gainor				
$\mathbf{\Sigma}$	2 should be and Mental Is markad aumatic av	은	19a. Informant's Name/Relationsh			19b. Mailii	na Address	(Street a			al Route Numbe	or City or To	own State. Zic	Code)	
Maryland	s 1 and 2 should be filed f Health and Mental Hyg item 27 Is markad otha othar traumatic avent,		Ruth Mora/Daug				•				ale, Per				
85	1 an Heal em 2		20a. Method of Disposition	511001	20b. F						Date		ion - City or To		
و	ages nt of : If it		1 🕅 Burial 2 🗆 Cremation		ate Gi	Place of Dispo emetery, cree IDIN Mi	^{matory`or o} anor	ther plac	9)		h 31,		•		
Ë	mit. Pa partmen cortant: injury		`4 □Donation 5 □Other (Sp		Mer	morial	Park			2006)	Elkt	on, Mai	yland	
Baltimore	pernit. Pages 1 a Department of Hes Important: If item any injury or otha once.		21. Signature of Funeral Service L	Icensee /		, H	2. Name an icks	d Addres Home	for	y Fune	erals, P	.A.			
	40200		Musterill	ICEN [M	mon								Maryla	and 219	121
			23a. Part1 Enter the disease, or of shock, or heart failure. List of	omplications that cau only one cause on eac	sed the deat th line.	n. Do not ent	ter the mod	e of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Betw Onset and D	reen
	Physician	1	Immediate Cause (Final disease or condition	a Ho	Se	-11/4	1000	ro	le and	1_	nyages	from 1	0185 HIC	- 2 l	i P
	/Medical		resulting in death)	Due to (or	as a conseq	uence of): /		-		10	0	1			
	Examiner		Sequentially list conditions.	b. 600	2 C	me	200	BU	2	16	ast	Jon	lac	200	445
	ס ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):)			,						' '
V	be executed ician and burial-transit	am	that initiated events resulting in death) Last	0. Con	na	19 H	STE	2	-	1	11500	26_	- 2	10my)	geans
Ö,	ate be execu nysician and he burial-tra		resulting in death) Last	Due to (or	as a conseq	uence of):								. ,	
8760	ate nys he	llca		d					···						
9	that the death certifical ed by the attending phy detached for use as th	Physician/Medical	IF FEMALE:												
Box	tth ce tend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 ☐ Live birt	me of pregna h 2 □Feta		□Ectopic pr	egnancy				23d	. Date of delive Month	-	ear
	e dea	sicl	1 ☐ Yes 2 ☐ No	4□Pregnar 9□Unknow	nt at time of d	eath 5	Other (sp	ecify)					MONTH	Day 16	adi
P.0	at the l by ti	hy	9 🗆 Unknown												
	og u		Part II. Other significant condition	ns contributing to dear	th but not res	ulting in the u	nderlying c	ause give	n in Part I				contribute to th		
p	w require been si	ed	Dahe	Hen IVI	ell	WHI	7				1 U Y	es 2 🔟 🗛	lo 3 ☐ Prob	ably 4 □Ur	ıknown
သို	aw re	Completed by	Con Ren.	a (This	nds	500	en	2			24a. Was		4b. Were auto	psy findings av	vailable
Ä	The I	шо			0						perfor	med?	death?	2□ No	126 OI
ta		യ	25. Was case referred to medical						26. Place	of Deat	h (Check only o				
Division of Vital Records,	Phyaician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ №	Hospital: 1 Inp	atient 2	ER/Outpatier	nt 3 DC	Othe	·		me 5 Desig		Other (Specifi	/)	
0	a Ph		27. Manner of Death	28a. Date of		28b. Time o		8c. Injury Work			28d. Describe h			7	
o	Attending r death. Bctor: After by the fune	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investig.		Day (Gai)	Injury	М		/es 2 🗆	No					
/s	Attendir death.	ifica	3 ☐ Suicide 6 ☐ Could n	289. Place of	Injury - At ho	ome, farm, sti	reet, factory	, office			28f. Location (S	Street and N	umber or Rura	I Route Numb	ΘΓ,
Ö	afte Dira	ert	4 Homicide	building	, etc. (Specif	<i>y)</i>					City or Tow	m, State)			
r	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Certification:	29a. Certifier 1 Certifying	Physician: To the b	est of my kno	wledge, deat	h occurred	at the tirr	e, date an	d place,	and due to the	cause(s) and	d manner as si	ated.	
•	e Ho 1 24 l	dic	(Check only 2 Medical E	xaminer: On the bas and manne	is of examina r stated.	ition and/or in	vestigation,	in my op	oinion, dea	th occur	red at the time, o	date and pla	ce, and due to	the cause(s)	
_	To the within 2 To the complet	Me	29b. Signature and title of certifier	000111	2 -		- 290	. License	number	2.5		29d. Date si	gned (Month,	Day, Year)	
			Harjert	exiCH.	4	mi	5	72	2-3	0	7	Mass	ch 2	8,20	506
	. ^		30 Name and address of person v	vho completed cause	of death (Item	n_23a) (Tyne	Print)		1	1		(
	12		JATANTILA	KATE	FLMI	1) 122	3 5574	gen	ly A	We.	ELK	TON	mi) a	2192	1-
	Sta	te.	31. Date filed (Month, Day, Year)=	32. Bèc	istrar's Signa	ature	1010	0	- ('			·	. /	, , =	
	Registr		Ann a -	2000		H A	anti s								
			APK U 5	LUUD I	was h	5 10									

DHMH 17 Rev 1/2001

ORIGINAL

		·	1 - For State Registrar	State of M	aryland	•	artment rtificate					iene	6	10514
			1. Decedent's Name (First, Middle	, Last)						2.	Date of Deat	h	Vand	3. Time of Death
	Physici		SAYIR	KOCA	<u> </u>						Month 3	20 7	ZOOL	6:15° DM
	/Medic Examin		4a. Facility Name (If not institution	give street and number,			4b. City, 7	Town, or	Location o	of Death		4c. County	of Death	,
	2,000	Ψ.	WASHINGTON A	H TYTHIS VC	MIDIC		M	Kom	AP	ARX		Mo	NTO	YSIZMO
	Funeral		5. Social Security Number	101	ge in yrs. las		If Under		If Under		Date of Birth (Month, Day,			place (State or Foreign
	Director		218-98-3629	1 th M 2□F	66	Yrs.	Months	Days	Hours	Min. Jι	ily 12,	1939		key
	ը .		Usual Residence of Decedent											
	show dat	_	10a. State 10b. County		Toc. City,	Town or Lo	cation							0d. Inside City Limits 1 ☐ Yes 2∜☐ No
	Ba-f.	cto	Maryland Montg	omery	Silv	er Sp	ring							
	ih th	Director	10e. Street and Number				10f. Zip				1	0g. Citizen of		ntry?
	23a	ai	506 Easley St					20910				Turke		
	r de	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Specif 1, Puerto Ric	y Yes or No- an, etc.)		ce - Americ ck, White,	ean Indian, etc.
36	orl	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No		1 ☐ Yes 2	2 No	Specify:			Specif	White	2
Ö	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show Isdical Examinat must be notified at			Year or Dates:		10- D	de este literre	10	41			16b. Kind of B		
쟌	"ina	Completed	15. Decedent (Specify only highes			(Give	dent's Usua kind of wor DO NOT us	k done a	uring most	t of working		IDD. KING OF D	usmess/m	dustry
12	har th	me	Elementary/Secondary (0-12)	College (1-4or	5+)		oe Re					Servi	CB	
2	be filed vital Hygie od othar levant, II		17. Father's Name (First, Middle,	Last)				Pall		er's Name (F	irst, Middle, I	Maiden Sumar		
an		To Be	Sukru Kocak						Sal	hanik	Kaya			
<u></u>	2 should be and Mental Is marked a	F	19a, Informant's Name/Relationsl	nip (Type, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Rural R	loute Number	City or Town	State, Zip	Code)
Maryland 21215-0036	od 2 :		Kalilya Kocak/	Wife		506	Easle	y St	reet	, #203	3, Silv	er Spr	ing,	MD 20910
ē,	Hea Hea tem otha	1 8	20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Nam	e of	-1	Date		20c. Location	- City or To	own, State
10	and		M☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Si)		matory or ot even Ce	-	.	March 200		Silver	Sprin	ng, Marylan
Baltimore,	artme ortar injur		21. Signature of Funeral Service								_	Home		.g, naryran
B	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic engice.		A Drung	: Orale	~	5	00 Un	iver	sity	Blvd,	W, Si	ilver S	pring	, MD 20901
			23a. Part1. Enter the disease, or	complications that cause	d the death.	Do not en	ter the mode	e of dying	g, such as	cardiac or re	espiratory arr	est,		Approximate
ш			shock, or heart failure. List Immediate Cause (Final	22390		1. ~		1						Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as			MCJ.	<i>~</i>					-	
	Examiner													
		ē	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as	s a conseque	nce of):								
	uted d ansit	Examine	Cause (Disease or injury that initiated events											
oʻ.	te be executed ysician and ie burial-transit		resulting in death) Last	Due to (or as	s a conseque	nce of):								
8760	cate be executed oblysician and the burial-transit	ical		d										
9	death certifica e attending phy of for use as th	ed)	1	-	-								
Box	death certifica attending ph for use as the	an/A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth]Ectopic pre	vonsnov					ite of delive	
	ie deal the att hed fo	Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐ Unknown			Other (spe					M	onth	Day Year
P.0	tac tac	Physician/M	9 🗆 Unknown		-									
	es tha gned be de	by	Part II. Other significant condition	ins contributing to death I	but not result	ing in the u	inderlying ca	ause give	en in Part I.					he cause of death?
ord	w requires t been signe should be	ed	EMPHYSE ON A					-			1 ∐ Ye	es 2 No	3 🗌 Prot	pably 4 Hinknown
Vital Records,	8 2	Completed	4								24a. Was a autops		Were auto	ppsy findings available mpletion of cause of
H	The ate h page	Хоп									perform	ned?	death?	
ita	ill ill i	Be	25. Was case referred to medical examiner?						26. Place	of Death (C	Check only on	(e)		
*	nysicia nis cert direct	2	1 □ Yes 2 □ 16	Hospital: 1 Inpati	ient 2	PVOutpatie	nt 3 🗆 DO	A Othe	er: 4 □ Nu	ırsing Home	5 🗌 Reside	ence 6 Oth	ner (Specif	(y)
n of	ding Ph h. After thi funeral	:uc	27. M. nn → of Death 1 atural 5 Pendin	28a. Date of Inj (Month, Da		28b. Time o	if 2	8c. Injury Work	at ?	280	d. Describe ho	w injury occur	red	
Sio	Attending ir death. ector: After by the fune	cati	2 Accident investig	gation			М	1 🗆 '	res 2					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could a determ	ited 286. Place of II	njury - At hom etc. <i>(Specify)</i>	ne, farm, st	reet, factory	, office		28f	. Location (Si City or Town		ber or Rura	al Route Number,
	rs af		/											
	Hospital	edicai	(Check only 2 Medical	g Physician: To the besi Examiner: On the basis	of examination									
	the the	Med	29b. No name and little of certifie	and manner s	tated.		200	License	number		2	9d. Date signe	ed (Month	Dav. Year)
	To T		and the or certifier						127			_		
*	4	1	- Jacob	***		30-1 =	D.1-1)		11/			03-2	2 - 0	2006
	1		30. Name and address of nerson	who completed cause of	The second	23a) (Type,	Print)	110		Const !) NON	CW.		
			31. Date filed (Month, Day, Year)	32 Regis	7600 tran's Signate	cur	2511 64	40	(DIX	COMA	J. N.C.	1111		
	Sta Registi		MAR 2 2	2006	nes D	A AM								
			MULITY IN F	- 1										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 21 2006 EUGENE MARCH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. MAY 17, 1925 KENT HOSPITAL CENTER CHESTER RIVER 7. Age (In yrs. last birthday) 80 Yrs. Birthplace (State or Foreign Country) **Funeral** . Social Security Numbe 217–20–9918 1∭ M 2□ F Yrs. MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show the Medical Exemples must be notified at MD QUEEN ANNE'S 1 Yes 2 No CHESTERTOWN Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 229 RIVER ROAD 21620 USA 238 Pages 1 and 2 should be filed within 72 hours after death value the balls and Mental Hygene.

and: If item 27 is marked other than "natural", or Items 23a and it item 2 than the manatic event, the Maulton Event and Internation. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify. 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION INSPECTOR STATE GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JOSEPH EDWARD KIRSCH MARGARET E. HAMMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHANIE LIGUORI/DAUGHTER 9 WIGEON PL., WYOMING, DE 19934 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Neurial 2 Cremation 3 Removal from State Department of important: If any injury or once. CRUMPTON CEMETERY 03/25/2006 CRUMPTON, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee 23a, bart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause og each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cla /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown NO 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No certificete 1 🗆 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes Inpatient 2 ER/Outpatient 3 DOA this Director: After thin in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I 29a. Certifier 🔂 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who comple

MAR 2

3 2006

31. Date filed (Month, Day, Year)

cause of death (Item 23a) (Type, Print)

ar's Signature

32. Regis

DAVID A. LOFTON 06-02087 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a, 27, 28a-f, penME, C854, 4/6/06 TT State of Maryland / Department of Health and Mental Hygiene **RKD** Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** MARCH 2006 9:43A. DAVID A. LOFTON /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1176 WASHINGTON BLVD BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. Sept. 8, 1961 Washington, Director 212-80-3705 44 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show 1 Yes 2 No Prince George's Maryland Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11218 Cherry Hill Road, #102 20705 U.S.A. filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Brick Mason <u>Private</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 is marked off jury or other traumatic even Be Arthur William Leebrick Deanna Lofton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deanna Lynn Lofton - Mother 11218 Cherry Hill Road #102, Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If sny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 03/28/2006 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Line 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications in at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chais on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Heroin intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to minimaliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Dinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 2 ☐ No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ۵ 1 XYes 2 No SCENE 28b. Time of Injury Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 21 No Fnd 3/25/2006 Fnd 9:30 AM 2 Accident 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1176 Washington Blvd. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Baltimore, MD Found in house Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. MARCH 25, 2006

DHMH 17 Rev 1/2001

State

Registrar

CAROL

31. Date filed (Month, Day, Year)

H

MAR 2 8 2006

111 PENN STREET BALTIMORE, MARYLAND 21201

pleted cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 115

2	19	100	5	dis
ľ	1 1	fra.	1	
- 1	1.3	UE	-1	

						Cert	ificate of	Death		Reg. No.	10 1	10017
	Dhusia	ų	1. Decedent's Name (First, Middl	e, Last)					2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medi		Margaret Magdel	ina Lekas						21 , 2006		9:45 pm
	Examir		4a Facility Name (If not institution	n, give street and number)				4b. City, Town,	or Location of Deat	h 4c. County	of Death	
			Pine View Futur	e Care				Clinto		Prince	Georg	ge
	Funeral		5. Social Security Number	1 □ M @ @ E	ө (In yrs. last b —	-	If Under 1 Year Months Days		Hrs. 8. Date of Bid Ain. (Month, Da	th ly, Year)	Birthplac Country	ce (State or Foreign
	Director		577-88-5978		5	Yrs.			Nov. 2	7,1920	New C	Jersey
	bu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loca	ation				10d	I. Inside City Limits
	/anyta	5										1 ☐ Yes 21☑ No
	tha N	Director	Maryland Prin 10e. Street and Number	ce George	Cap.	ILai	Heights			10g. Citizen of V	What Country	12
	A P	ā		1								
	eath	Funerai	4006 Will Stree	12. Was Decedent	Ever in U.S.	13. W	20746	dispanic Origin	(Specify Yes or No	U.S.A.	e - American	Indian.
	far d	ᆵ	1√√Never Married 2 Marr	Armed Forces?		if	Yes, specify Cub	an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Blac	ck, White, etc	
22	urs al	þ	3 ☐ Widowed 4 ☐ Divorced	IT YAS GIVA		1[□Yes 2□XNo	Specify:		Specify	White	Э
21215-0020	should be filed within 72 hours after death with the Maryland of Manial Hygiana. marked other than "natural", or items 23e or 28e-f show immite event, the Medical Experient must be notified at	Completed by		t's Education	16	a. Decede	nt's Usual Occup	pation		16b. Kind of Bu	usiness/Indus	stry
215	hin 7	pie	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4or 5	5+)	(Give ki	ind of work done O NOT use retire	during most of d)	working			
21	filed within Hygiana. other than ant, the M	Eo	7	00110g0 () 401 t		nknow	n			Unknow	m	
b	a file othe vant	Be	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Middle	, Ma <i>iden Sum</i> am	Θ)	
<u>la</u>	uld b Vanta rked rice	P	John Lekas					Bess	ie	Unknown	i .	
Maryland	s 1 and 2 should be t f Haalth and Mantal I fam 27 is merked of other traumetic eve	.	19a. Informant's Name/Relations	hip (Type, Print)	19	9b. Mailing	Address (Street	and Number o	r Rurai Route Numb	er, City or Town,	State, Zip Co	ode)
	D = 1 = 0		Catherine Cowa	n Niece				4, India	an Head,	Md. 2064	0	
<u>Jre</u>	of Harrich		20a. Method of Disposition	0 □Demoval from State	20b. Place cemet	of Disposi tery, crema	tion (Name of atory or other pla	ce) March	27,2006	20c. Location -	City or Town	i, State
Ĕ	Page nant int: M		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Wash	ingto	n Natio	nal Cem	etery	Suitlan	id. Mar	cyland
Baltimore,	parmit. Pagas 1 an Dapartmant of Haal Important: If Itam 2 any Injury or other pnce.	Ì	21. Signature of Funeral Service	Licensee		1	Name and Addre					
8	20 E 2 8		hata		MOOCCO	Wi	lliams l	Funeral	Home, P. d., India	A.	NG OM	0640
			23a. Part1. Enter the disease, or shock, or heart fallure. List	complications that caused	M00668 the death. Do	o not enter	the mode of dyi	ng, such as car	diac or respiratory a	rrest,	Ar	pproximate
- wing	Physician		snock, or near trailure. List	only one cause on each III	ne.						Ö	iterval Between Inset and Death
A.	/Medical		Immediate Cause (Final disease or condition	a CERE	BROW	ACM	11/ KR	Δ	SEASE			
-	Examiner	ž	resulting in death)	a. C	Due to (or as	, , –	ence of):	1/	1/100			
196	D #	Examiner										
	artificata be axacuted ling physician and a as tha burial-transit	E	Sequentially list conditions,	·	Due to (or as a	a conseque	ence oi):					-
90	oe ax cian a		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
68760,	sata t physic	Medicai	that initiated events resulting in death) Last		Due to (or as a	conseque	ence of):					
×	oartific Inding p usa as	Me		d								Ш
Bo	at Por	Physician/									1	
o	at the de by the s stached	ysic	Part II. Other significant condition	ns contributing to death b	ut not resulting	in the und	lerlying cause gi	ven in Part I.				ne cause of death?
P.0	that that the	된	DEMENTI	A					1 🗆	Yes 2□ No	3 Probab	bly 4 Unknown
ds,	S P B	yd k	- St 2010 1 1						249 14/96	an autopsy	24h Were	autopsy findings
Ö	v raquiras bean sign should ba	etec							perfe	ormed?	availa	able prior to detion of cause
ec	as the same	Completed								1/	of dea	ath?
=	Pag ata	8							1 🗆	Yes 2 No	1 🗆 Y	res 2□ No
Vital Records,	Physician: Tha I this cartificata ha ral diractor, paga	Be	25. Was case referred to medical examiner?				04		Death (Check only			
ot	Physic this cral dir	2	1 Yes 2 No	Hospital:	1	Dutpatient	3LI DOA	4 Nursir	g Home 5 Resi			
E	Ing F	0	27. Manner of Death 1 Natural 5 □ Pendin		y Year)	. Time of Injury	28c. Inju Wo M 1 □	rk? Yes 2∐No	26d. Describe	how injury occurr	60	
Si	Attending ir daath. octor: Aftai	Cat	Accident investig 3 ☐ Suicide 6 ☐ Could	not be	un. At homo	form street		1103 2 110	28f Location /	Street and Numb	er or Pural E	Zoute Number
Division	or Attar of Direction by	Certification:	4 ☐ Homicide determ	28e. Place of Injuding, etc		iami, suec	st, lactory, office		City or To	wn, State)	Bi Oi Huiai II	oute realition,
	lospital 4 hours a uneral [aly filled	2	29a. Certifier Certifyin	g Physician: To the best of	of my knowledg	ne death o	occurred at the ti	me date and n	ace, and due to the	cause(s) and ma	nnor as etate	od.
	Hos Pun Fun	edicai		Examiner: On the basis of and manner sta	examination a							
	To the Hospital or Attending F within 24 hours aftar death. To the Funeral Director: Aftar complataly filled in by the funer	Me	29b. Signature and title of certifie				29c. Licens	se number		29d. Date signed	d (Month, Da	y, Year)
	⊢ ≯ ⊢ ŏ			-ILLA			0	1791	6	7/-	17/2	
		-	30. Name and address of person	who completed cause of d	eath (Item 22a) (Type P	rint)	010	0	2/4	-40	0
Λ	194						01-	Line 1	ENTER 4	207 WM	nock A	nd 20002
1,	Sta	te.	31. Date filed (Month, Day, Year)	32. Registr	D. 12 ar's Signature	10	1 4	MINING C	-1201 101 0	716	-0.04	
	Registr	- 4	MAR	2 2 2006	suce 1	5. 16	DOME					

DHMH 17 Rev 1/2001

PATRICIA LAMBERT

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

_	1 - For State Registrar				Cer	tificate of L	Death			Reg. No.			
an	Decedent's Nam								Date of De Month	eath Day	Year		Dea
cal			s Lowery			# C2 T	1 2		March	15	200		
ner			n, give street and n hbaum Roa			4b. City, Town, or				4c. C	ounty of Dea		
	5. Social Security		6. Sex	7. Age (In yrs.	last birthday)	Corrig	ganvı. If Under 2		8. Date of Bi	rth.	Alleg	any nthplace (State o	or Fo
	213-13-		1 ⊠ M 2□F	10	Vre	Months Days	Hours	Min.	(Month, Di 8-18-	ay, Year)	C	MD	,,,,
	Usual Residence of		1						0-10-	700		IVID	
_	10a. State	10b. County			y, Town or Lo							10d. Inside C	
Director	MD	All	egany	Co	rrigan	ville						1 🗆 Yes	21
Dire	10e. Street and Nu	ımber				10f. Zip Code				10g. Citize	en of What C	country?	
ra	12513	Suder			- 1	21524				us			
Funeral	11. Marital Status	aind OFT Mas	Armed F		S. 13. V	Vas Decedent of His f Yes, specify Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	0- 14	Black, Wh	erican Indian, ite, etc.	
by F			If Yes. G	2 X No Sive Dates:	1	Yes 22 No	Specify:			s	pecify: W	hite	
ed		15. Deceden	nt's Education		16a. Deced	lent's Usual Occupa	ation			16b. Kind	of Business	s/Industry	-
ple	(Spe Elementary/Sec		est grade completed	(1-4or 5+)	(Give life. L	kind of work done di DO NOT use retired)	luring most)	of worki	ng			,	
Completed	1	2	0011090	(1 40/ 01)	Machi	ne Operat	or			Indi	ustrio	ıl Laund	'nι
Be		(First, Middle,	Last)				18. Mother	r's Name	(First, Middle	, Maiden Si	umame)		
2	Alan M	larvin					Su	san	Parry			0.50	
	19a. Informant's N					g Address (Street a						Zip Code)	
-	<u> </u>		ry / Fath			Box 310 (corre						
	20a. Method of Dis 1 ☑ Burial 2	•	3 Memoval from		lace of Dispo: emetery, cren	sition (Name of natory or other place			ate		•	r Town, State	
		5 Other (S			rter (Cemetery	į.	3-20	-2006	Нупа	lman,	PA	
	shock, or head shock,	art failure. List (Final on		each line. Cowtau	t gu	rvey H. 2 er the mode of dying un Shot v	g, such as o	cardiac c	or respiratory a	arrest,	, ₋ Hyndi	Man, PA Approximat Interval Bet Onset and	e wee
Já	shock, or her Immediate Cause disease or conditi- resulting in death)	art failure. List (Final on	aDue to	Contine. Contine o (or as a consequence)	uence of):	er the mode of dying	g, such as o	cardiac c	or respiratory a	arrest,	- Hy ^{ndi}	Approximat Interval Bet	e wee
niner	shock, or head immediate Cause Cause. Enter Und. Cause Clisease or condition resulting in death) Sequentially list or if any, leading to it cause. Enter Und. Cause (Disease or Cause (Disease	art failure. List (Final on moditions, mmediate erlying riniury	aDue to	each line. Cowtau	uence of):	er the mode of dying	g, such as o	cardiac c	or respiratory a	arrest,	, ₋ Hyndi	Approximat Interval Bet	e wee
Examiner	shock, or hea Immediate Cause disease or conditi resulting in death)	art failure. List (Final on moditions, mmediate erlying r injury s	a	Contine. Contine o (or as a consequence)	uence of):	er the mode of dying	g, such as o	cardiac c	or respiratory a	arrest,	. Hyndi	Approximat Interval Bet	e wee
cal Examiner	shock, or het Immediate Cause disease or conditi- resulting in death) Seque time, last cu- if any, leading to in- cause. Enter Und. Cause (Disease or that initiated event	art failure. List (Final on moditions, mmediate erlying r injury s	a	each line. Control (or as a consequence of control (or as a control (or	uence of):	er the mode of dying	g, such as o	cardiac c	or respiratory a	arrest,	, - Hy ^{ndi}	Approximat Interval Bet	e wee
ā	shock, or hei Immediate Cause disease or conditi- resulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death)	art failure. List (Final on moditions, mmediate erlying r injury s	a	each line. Control (or as a consequence of control (or as a control (or	uence of):	er the mode of dying	g, such as o	cardiac c	or respiratory a	arrest,	Hy ^{ndi}	Approximat Interval Bet	e wee
cian/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Sequentially list or if any, leading to in cause. Enter Und. Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12	art failure. List (Final on moditions mediate ertying s injury s Last the pregnant months?	a	each line. Con true o (or as a consequence of or as a consequence of pregnation birth 2 Fetal grant at time of de	uence of): uence of): uence of): uence of):	er the mode of dying	g, such as o	cardiac c	or respiratory a	nest	d. Date of de Month	Approximation interval Bet Onset and	e wee Dea
Physician/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Sequentially list or if any, leading to it cause. Enter Und. Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown	art failure. List (Final on Inditions Inditio	a	each line. Con-true o (or as a consequence of or as a consequence or a consequence of or as a consequence or a c	uence of): uence of): uence of): uence of):	Ectopic pregnancy Other (specify)	g, such as c	cardiac c	of C	nest	d. Date of de Month	Approximal Interval Bet Onset and	e wee Dea
by Physician/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Secuse tially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on Inditions Inditio	Due to a Due to b Due to d 23c. If yes, or 1 □ Live 4 □ Preg 9 □ Unk	each line. Con-true o (or as a consequence of or as a consequence or a consequence of or as a consequence or a c	uence of): uence of): uence of): uence of):	Ectopic pregnancy Other (specify)	g, such as c	cardiac c	of C	23	d. Date of de Month	Approximation interval Better and Interval	e wee Dea
by Physician/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Secuse tially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on Inditions Inditio	Due to a Due to b Due to d 23c. If yes, or 1 □ Live 4 □ Preg 9 □ Unk	each line. Con-true o (or as a consequence of or as a consequence or a consequence of or as a consequence or a c	uence of): uence of): uence of): uence of):	Ectopic pregnancy Other (specify)	g, such as c	cardiac c	23e. Did	23d fobacco use	d. Date of de Month confribufe t No 3 P	Approximate Interval Bet Interv	e wee Dea
by Physician/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Secuse tially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on Inditions Inditio	Due to a Due to b Due to d 23c. If yes, or 1 □ Live 4 □ Preg 9 □ Unk	each line. Con-true o (or as a consequence of or as a consequence or a consequence of or as a consequence or a c	uence of): uence of): uence of): uence of):	Ectopic pregnancy Other (specify)	g, such as c	cardiac c	23e. Did 1 24a. Was auto	fobacco use Yes 2 🕅	d. Date of de Month e confribufe t No 3 P	Approximation interval Better and Conset and	e wee Dea
e Completed by Physician/Medical	shock, or hei Immediate Cause Immediate Cause disease or conditi- resulting in death) Secular tially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1 Yes 2 9 Unknown Part II. Other signi	art failure. List (Final on conditions mediate ertying s injury s Last the pregnant the months? No	a	each line. Con-true o (or as a consequence of or as a consequence or a consequence of or as a consequence or a c	uence of): uence of): uence of): uence of):	Ectopic pregnancy Other (specify)	n, such as d	cardiac c	23e. Did 1 1 24a. Was auto perfe	fobacco use Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	d. Date of de Month e confribufe t No 3 P	Approximate Interval Bet Interv	e wee Dea
o Be Completed by Physician/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on myself failure. List (Final on myself failure. myself failur	a	each line. Con-true o (or as a consequence of or as a consequence of pregnation birth 2 Fetal grant at time of death but not results.	uence of): uence of): uence of): uence of):	Ectopic pregnancy Other (specify)	n in Part I.	of Death	23e. Did 1 1 24a. Was auto perfect 100 Yes	fobacco use Yes 2 1 1 No one	d. Date of de Month confribufe t No 3 P 24b. Were a prior to de in?	Approximation interval Bet Onset and	e wee Dea
To Be Completed by Physician/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Sequentially list or if any, leading to in- cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on conditions mediate ertying sinit pregnant ertying s Last the pregnant ertying s months? No conditions ficant conditions fired to medica	a	each line. Control o (or as a consequence of or as a consequence of pregnation of pregnation of the consequence of the conseq	uence of): EP/Outpatien 28b. Time of	Ectopic pregnancy Other (specify)	on in Part I. 26. Place	of Death	23e. Did 1 24a. Was auto perfit 104 Yes. 10 Check on 10 me. 5 Pesi 28d. Describe	fobacco use Yes 2 1 No one idence XX	d. Date of de Month confribufe t No 3 P 24b. Were a prior to de in? 1 Yes	Approximately and a completion of completion	e wee Dea
To Be Completed by Physician/Medical	shock, or hei Immediate Cause disease or conditive sulting in death) Sequentially list or if any, leading to it cause. Enter Und Cause (Disease of that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on middle is middle	Due to a	each line. Con-true o (or as a consequence of or as a consequence of pregnation at time of death but not result in the consequence of the conseq	uence of):	Ectopic pregnancy Other (specify) aderlying cause given 3 DOA Other	on in Part I. 26. Place	of Death	23e. Did to the control of the contr	fobacco use Yes 2 1 No one idence XX	d. Date of de Month confribufe t No 3 P 24b. Were a prior to de in? 1 Yes	Approximately and a completion of completion	e wee Dear
To Be Completed by Physician/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Secusiting ist or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on Another is mediate errying or injury s Last At pregnant condition ficant condition rred to medica No th 5 Pendir	Due to b. Due to c. Due to d. 23c. If yes, o 1 Live 4 Prec 9 Unk ons contributing to 11 Hospital: 28a. Date one include in the contribution of t	each line. Control o (or as a consequence of or as a consequence of pregnation birth 2 Fetal grant at time of displayment at the control of	uence of): uence	Ectopic pregnancy Other (specify) aderlying cause given 28c. Injury Work 1 1 Y	on in Part I. 26. Place 27. 4 \(\) Nur af?	of Death	23e. Did 1 1 24a. Was auto performed to 1 1 24a. Was auto performed to 1 25 28d. Describe 200 28d. Describe 200 28d. Describe 200 28d.	fobacco use Yes 2 1 No one idence XX how injury of	d. Date of de Month confribufe t No 3 P 24b. Were a prior to de th? 1 Yes	Approximation and interval Bet Interval Bet Onset and Interval Bet O	e wee Dear
Certification: To Be Completed by Physician/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Sequentially list of if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on mediate ertying rinjury s Last at pregnant months? No fificant condition fred to medica No th S Pendir F Pendir G Could	Due to b. Due to c. Due to d. 23c. If yes, o 1 Live 4 Prec 9 Unk ons contributing to 11 Hospital: 28a. Date one include in the contribution of t	each line. Con-true o (or as a consequence of or as a consequence of pregnation at time of death but not result of the consequence of the conseq	uence of): uence	Ectopic pregnancy Other (specify) aderlying cause gives 28c. Injury Work O M 1 1 Y eet, factory, office	on in Part I. 26. Place 27. 4 \(\) Nur af?	of Death	23e. Did 1 24a. Was auto performed to 1 25 Resided Describe 226f. Location (City or To	fobacco use Yes 2 1 No one idence XX how injury of	d. Date of de Month confribufe t No 3 P 24b. Were a prior to de th? 1 Ye: Clother (Special Control of the C	Approximate Interval Bet Onset and O	e wee Dear
edical Certification: To Be Completed by Physician/Medical	shock, or hei Immediate Cause disease or conditi- resulting in death) Sequentially list of if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on conditions mediate ertying riplury s Last th pregnant months? No ficant condition fred to medica No th 5 Pendir investi 6 Could determ	Due to a	each line. Control o (or as a consequence of or as a consequence of pregnation of pregnation of the consequence of the consequence of the consequence of line of l	uence of): uence	Ectopic pregnancy Other (specify) aderlying cause given 28c. Injury Work 1 Y est, factory, office	g, such as d on in Part I. 26. Place or af ? ees 2 N ne, dafe and	of Death	23e. Did 1 1 24a. Was auto perfection of Check on Nome 5 Resided Describe Subject 28d. Describe 28d.	fobacco use Yes 2 No one idence XX how injury of wn, Street and wn, Street and wn, State) rigan v. cause(s) ar	d. Date of de Month confribufe t No 3 P 24b. Were a prior to de in? 1 Yes Clother (Specurred Wumber or Fi	Approximate Interval Bet Interval Bet Onset and Interval Bet Onset Interval Bet	e wee wee wee wee wee wee wee wee wee w
Certification: To Be Completed by Physician/Medical	shock, or hei Immediate Cause disease or conditive sulting in death) Secular tially list or if any, leading to it cause. Enter Und Cause (Disease or that initiated event resulting in death) IF FEMALE: 23b. Was deceder in the past 12 1	art failure. List (Final on Anothicus mediate erlying rinjury s Last Ant pregnant months? No fificant condition fred to medica No th Could determ Certifyir Certifyir Certifyir Certifyir Certifyir	Due to a	each line. Control o (or as a consequence of or as a consequence of pregnation birth 2 Fetal grant at time of denown death but not restant a finite of the control of the	uence of): uence	Ectopic pregnancy Other (specify) aderlying cause given 28c. Injury Work 1 Y est, factory, office	an in Part I. 26. Place 37. 4 Nur af res 2 N	of Death	23e. Did 1 1 24a. Was auto perfection of Check on Nome 5 Resided Describe Subject 28d. Describe 28d.	fobacco use Yes 2 1 No one idence XX how injury of the win, Street and I www. Street and I cause(s) ar date and pl	d. Date of de Month No 3 P 24b. Were a prior to de in? 1 Yes Clother (Special Control of the	Approximate Interval Bet Interval Bet Onset and Interval Bet Onset Interval Bet	e wee bear fear fear fear fear fear fear fear f

State Registrar

31. Date filed (Month, Day, Year) WAR 2 2 2006 32. registrar's Signature

			For State Registrar	State of	of Maryla		artment of F			giene	16	10620
	#		Decedent's Name (First, Middle, L.	ast)					2. Date of De		Year	3. Time of Death
	Physici /Medic	al		nch,Sr					March	16 2	006	12:12 PM
	Examin	er	4e. Fecility Name (If not institution, gi		mber)		Lanhar	r Location of Deat 11	th		ty of Death	eorges
	Funeral Director		5. Social Security Number 6. 158-20-1979	Sex 1 ★ M 2 □ F	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir Month, Da Sept 9	th 19. 1930	Con	place (State or Foreign intry) nsylvania
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	cation					10d. Inside City Limits
	8a-f s	Director		Georges	Ri	iverdale						Yes 2□No
	with the	ai Dire	10e. Street and Number 6273 67th Ct.				10f. Zip Code 2073	7		10g. Citizen of		•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, I've Medical Examiner must be not lied at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	edent Ever in orces? 2 No 19 ive oates: 195	51-	Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	dispanic Origin? (S an, Mexican, Puer Specity:	Specify Yes or No to Rican, etc.)	Bt	ace - Amen ack, White, ify: Whi	
Maryland 21215-0036	ithin 72 ho he. han "natur Medical	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)			(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	rking	16b. Kind of		
7	lied w lygier ther th		17. Father's Name (First, Middle, Las	<u>Z</u>		lech	nical Di		me (First, Middle		visior	1
ylanc	Mental H Mental H arked of	To Be	William Lynch						Lynch	, waiden Sume	me,	
Mar	12 sho		19a. Informant's Name/Relationship				ng Address (Street				n, State, Zij	Code)
	1 and Health em 27		Joan Lynch/ Wife 20a. Method of Disposition	2	201	D. Place of Dispo	67th Ct		ale,MD 2	20c. Location	- City or T	own, State
Baltimore,	Pages ment of ant: # II		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State		natory or other place. 1 Cremate		2-06	Falls	Churc	ch, VA
Balt	permit. Departimport. any inj		21. Signature of Funeral Service Lice	Muua			Joseph G				on DO	20016
y 17			23a. Part1. Enter the disease for conshock, or heart failure/ ust only	nplications that/ y one cause on	aused the de	eath. Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Intervat Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a		12-	espirat	vry t	-A. lure			Onset and Death
ı	Examiner			Due to	(or as a cons	sequence of):	Sepsi verti	< '				
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a cons	sequence of):	11/1/12	++.				
o,	ficate be executed physicien and s the burial-transit	Examin	that initiated events resulting in death) Last	c	(or as a cons	sequence of):	iv-y to	ت را ر				
8760,	cate be physici the bu	dicai		d								
.O. Box 6	The law requires that the death certifisteness been signed by the ettending rage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 □ F nant at time o	etal death 3	Ectopic pregnancy Other (specify)	/			ate of deliv	rery Day Year
α.	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to c	leath but not	resulti <i>n</i> g in the u	nderlying cause giv	en in Part I.				the cause of death? bably 4 X Unknown
Division of Vital Records,	ician: The law requ certificete hes been rector, page 2 shoule	Completed							24a. Was auto perfo 1 \(\text{Yes}			opsy findings available omptetion of cause of 2 □ No
ŽĮ.	sician certif irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2	□ EB/Outpat	Oth	or	ath (Check only		than (Cara	4.3
o (ding Physician: h. After this certific funeral director,	n: To	27. Manner of Death	28a. Date		28b. Time o		y at	Home 5 ☐ Resi 28d. Describe	how injury occi		<u>'y)</u>
sior	tendin leath. tor: Af the fur	catic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on he			M 1 🗆	Yes 2 □ No				
DΪΧ	s after or All Direct of all Direct of by all Direct of the by	Certification:	4 Homicide determine	d 289. Plac	e of Injury - A ling, etc. (Spe		eet, factory, office		City or To	Street and Nun wn, State)	iber or Hur.	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, is	edicai	29a. Certifier the Certifying F (Check only one)	sminer: On the I	e best of my loasis of examiner stated.	knowledge, deat ination and/or in	h occurred at the tir vestigation, in my o	me, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and r date and place	nanner as s , and due t	stated. to the cause(s)
	within To the comp	ž	29b. Signature and title of certifier)_	N~0	29c. Licens	1 2 / 11		29d. Date sign	ed (Month,	Day, Year)
,	5		30. Name and address of person wh	completed care	se of death (I	Item 23a) /Tune		560611		31	1110	2006
	_		SAMUEL 1	2. AS	fav	3/18	600D LUCI	K RD 1	ANHAM /	40 20	70	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 1 21	006	Registrar's Signal	gnature	ili					

Lynch, Robert

			1 ⊷ For State Registrar		partment of Health and Mertificate of Death	ental Hygie Reg.	Z 1111
ī	q		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	Physici /Medic		Shirley Ann Lega	ar		March	22 2006 5:00 a ^M
	Examin	er	4a. Facility Name (If not institution, give str		4b. City, Town, or Location of Death		4c. County of Death
			1122 Dudleys Con		Millington Willington Willington	2 Date of Birth	Queen Anne's
П	Funeral Director			7. Age (In yrs. last birthda 58 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	
	ס		Usual Residence of Decedent	30		Feb. 29	1948 MD
	ırylan show	_	10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Ba-f s	Director	MD Queen Ar	nne's Sudlers			1 ☐ Yes 2 ☐ No
	with th	Dire	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	eath v	erai	5921 Sudlersvil		21668	oif. Van as Na	USA 14. Race - American Indian,
	fter d	by Funeral	11. Marital Status 12 Never Married 2 Married 12	Armed Forces? 1 Yes 2 XNo	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I **-	Rican, etc.)	Black, White, etc.
036	urs a		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:		Specify: White
Maryland 21215-0036	72 hours after death with the Maryland ineturel; or teme 23a or 28a-f show died Examinate the notified at	Completed	15. Decedent's Educa (Specify only highest grade	tion 16a. Dec	edent's Usual Occupation red kind of work done during most of work in	16b	b. Kind of Business/Industry
21	within ene.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	·9	
2	filed w Hygie Stherti ant, It		10 17. Father's Name (First, Middle, Last)	Se	cretary	(First, Middle, Maid	griculture
anc	d be f nital h ed of	Be	Clarence Samuel	Solloway		Marie Hu	~ · · · · · · · · · · · · · · · · · · ·
7	12 should be and Mental ris marked or reumatic ever	ြ	19a. Informant's Name/Relationship (Type	-	iling Address (Street and Number or Rura		
	train.		Bonnie Schelts/I		1.00		llington MD 21651
ē,	s 1 and 2 if Health item 27 i		20a. Method of Disposition	20b. Place of Dis	position (Name of Dematory or other place)		Location - City or Town, State
E	Page nent c int: If		1 ∯Burial 2 □ Cremation 3 □ Rei 1 □ Donation 5 □ Other (Specify)	noval from State	sville Cem. 3/25	5/2006	Sudlersville, MD
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signatur of uneral Service Licens	,	22. Name and Address of Facility		-
<u> </u>	89 5 8 9		Hary 12 te	(COUS	370 W. Cypress S	<u>St Milli</u>	ewnam Funeral Hom
			23a. Part1. Enter the disease, or complication shock, or heaft ailure. List only one	ations that caused the death. Do not e cause on each line.	nter the mode of dying, such as cardiac of	r respiratory arrest,	Approximate Interval Between
	Pnysician	1	Immediate Cause (Final disease or condition	metastati	c Lung Con	sces	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	J		
		<u>.</u>	Sequentially list conditions, b.	Cria to for as a consequence off:			
	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
ó	exec in and rial-tra	Еха	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
8760,	cate be executed physician and the burial-transit	dical	d.				
9	ing ph	a) +	IF FEMALE:				
Box	The law requires that the death certificate has been signed by the attending forge 2 should be detached for use as	ian/M	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of delivery Month Day Year
0	that the death ed by the atte detached for	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 Pregnant at time of death 5 9 Unknown	Other (specify)		
۵.	that the ed by detac	by Physici	Part II. Other significant conditions contr	ibuting to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
ds,	uires signe d be					1 🗆 Yes	2 No 3 Probably 4 Unknown
Vital Record	w requir been si should	ompleted				24a. Was an	24b. Were autopsy findings available
Re	The lay le has age 2	omp				autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ta		e C	25. Was case referred to medical		26. Place of Death	1 Yes 2	No 1 ☐ Yes 2 ☐ No
	Physicien: this certific ral director,	To B	examiner?	spital: 1 Inpatient 2 ER/Outpatient	Other	1	6 ☐Other (Specify)
0 0	ding Ph h. After thi funeral		27 Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury		8d. Describe how in	njury occurred
sio	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No		
Division of	l or Attencatter death Director: in by the	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 2	81. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	Hospital 24 hours 6 Funeral 19ly filled		29a. Certifier 1 Certifying Physic	ien. To the best of my knowledge, dea	ath occurred at the time, date and place, a	nd due to the cause	a(s) and manner as stated
	e Hos 24 h e Fur letely	edical			investigation, in my opinion, death occurre		
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certifier	00	29c. License number	29d.	Date signed (Month, Day, Year)
•			· / / /		D0005178	6	3-23-06
))			30. Name and address of person who com	pleted cause of death (Item 23a) (Type		~	
1	7		Dr. Andrew Fer	Jusen 120 St	Doer Rd, Bldg B	. Cheste	Hown MD 21620
•	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 3 7	32. Registrans Signature			
			1111111 A U C	And the state of t	1238463)		

			1 - For State Registrar		State o	of Maryla	ind / Dep <i>Ce</i>		nt of H		and Me	ntal Hy	/giene Reg. No.	006	10622
П	Physici	an	_	e (First, Middle, Las	•	,					2	Date of D Month	eath Day	Year	
	/Medic	al	LAR.				VGER	4h Ci	Taua or	Lanation		MARCH		2006 County of De	
	Examin	er		f not institution, give			CANTER		y, Town, or				40.	County of De	201
4.	Funeral		5. Social Security N	umber 6. Se			s. last birthday,) If Unc		If Under		Date of B	irth	9. B	rthplace (State or Foreign
П	Director		212-20-88	826	M 2□F	80	Yrs.	Month	s Days	Hours	Min.	3/15/	1926		rvland
	p ,		Usual Residence of 10a. State	Decedent 10b. County		100 (City, Town or L	anation							10d. Inside City Limits
	shov	'n	MD	Harford				_							1 Types 2 □ No
	the N	ect	10e. Street and Nur				Havre (Zip Code	-			10a Citi:	zen of What C	
	be filed within 72 hours after death with the Maryland ital Hygiene. bd other then "naturel", or Iteme 23e or 28e-1 show event, the Medical Examiner must be notified at	Funeral Director			Street			101. 2	2107	78			USA		ountry :
	death me 23	era	11. Marital Status			edent Ever in	U.S. 13.	Was Dec	edent of His	spanic Orig	gin? (Specif	fy Yes or N		4. Race - Am	erican Indian,
ڥ	after or Ite	Ē	1 🗆 Never Marri	ied 2 Married	Armed Fo	2 C No	-		ecify Cubai	n, Mexican Specify:	, Риепо нк	can, etc.)		Black, Wh	21
21215-0036	irel',	d by	3 ₩ Widowed	4 ☐ Divorced	Year or C	ive WII	-	103	2 X No	зреспу.				Specify:	hite
2	"natu	Completed	(Spec	15. Decedent's Ed lify only highest grad			(Give	kind of	vork done d	luring most	of working		16b. Kir	nd of Busines	s/Industry
7	within ene. then	E	Elementary/Seco	ndary (0-12)	College (1-4or 5+)			use retired,	,			Dub	lic Dr	otection
	e filed within al Hygiene. I other then '	e Cc	17. Father's Name	(First, Middle, Last)	0		<u> Fi</u>	refi	hter	18. Mothe	r's Name (/	First, Middl			OLECTION
an	should be nd Mental marked c	To B	Earl C	larence	Litzing	ger				Mae	Eve	lyn i	Nelso	n	
Maryland			19a. Informant's Na	ame/Relationship (7	ype, Print)	- .	19b. Mail	ing Addre	ss (Street a	ind Numbe	r or Rural F	Route Num	ber, City or	Town, State,	Zip Code)
	and 2 eaith a n 27 is		Collee:	n Waller	(Daugh	nter)	52	7 C	mi 11a	a St	., Æ	avre	de Gr	ace, M	D 21078
ore	of Heal of Heal if Item 2		20a. Method of Disp	oosition Cremation 3	Removal from	- 1	. Place of Disp cemetery, cre	osition (A matory o	lame of r other place	9)	Dat	9	20c. Lo	cation - City o	r Town, State
Ě	Pag ment ant:			5 Other (Specify		Ha	erford l						_	rdeen,	
Baltimore,	permit. Pages 1 am Department of Heali Important: if Item 2 any Injury or other once.			ed S. Z		, per I	OVR 2	2. Name Carr	and Addres	s of Facilit	y 333 S Funera	South al Ho	Park ne	e St.,	Aberdeen,MD 21001-2299
п			23a. Part1. Enter the shock, or hea	he disease, or comp rt failure. List only o	lications that one cause on	caused the de each line.	eath. Do not en	iter the m	ode of dying	g, such as	cardiac or r	espiratory	arrest,		Approximate Interval Between
T.	Physician		Immediate Cause (disease or condition		aI.	introck	ZANIAL	_ H	emo	RAHA	+GE				Onset and Death
	/Medical Examiner		resulting in death)			(or as a cons									
		<u>.</u>	Sequentially list con	nditions,	b. Due to	fur as a cons	univence of								
	ted nsit	Examiner	cause. Enter Unde Cause (Disease or that initiated events	erlying injury	Due to	(01 83 8 00113	equence on.								
	al-tra	xar	that initiated events resulting in death) t	Last	c. Due to	(or as a cons	equence of):								
68760,	icate be execu physicien and s the burial-trai	dicai			d										
_					d,										
Вох	law requires that the death certi as been signed by the ettending 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent	t pregnant		itcome of preg		Tectonio	pregnancy				2	3d. Date of d	,
B	a deat	sicie	in the past 12 1 ☐ Yes 2 ☐	□No		nant at time of		Other						Month	Day Year
P.O.	that the de led by the e detached f	P.	9 Unknown												
	res tha signed I be det	ρ	Part II. Other signif	ficant conditions co	intributing to c	leath but not r	esulting in the i	underlying	j cause give	en in Part I.			tobacco us		to the cause of death? Probably 4 Unknown
0.0	w require been sig should b	eted										-			
Sec.	e law has b	Completed										24a. Wa auto	s an opsy formed?	24b. Were a prior to death?	autopsy findings available completion of cause of
a F	iclan: Th certificete rector, pag											1□ Yes		1 □ Ye	s 22No
Ž	ysiclan: The is certificete hadirector, page	Be	25. Was case reference examiner?		Hospital:				Othe	· -	of Death (
ō	Phys rthis sraldi	To	1 Yes 2 2	140	1 2	Inpatient 2 of Injury oth, Day Year)	☐ ER/Outpatie		JUA	4 ∐ Nu		d. Describe		Other (Sp	ecify)
0	iding Phy th. : After thi s funeral o	후	1 Matural 2 ☐ Accident	5 Pending investigation	(Mor	nth, Day Year)	Injury	М	28c. Injury Work	(? Yes 2 ∐i					
Division of Vital Records,	or Attending Physiclen: The iter death. Director: Atter this certificete hin by the funeral director, page	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be	286. Plac	e of Injury - At	home, farm, st	reet, fact	ory, office		28				Rural Route Number,
Ö	s afte s afte of in l	Certification;	4 [] Honsicide		bullo	ling, etc. (Spe	icity)					City of 10	own, State)		
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai (29a. Certifier (Check only	1☑ Certifying Phy 2☐ Medical Exam	sician: To the	e best of my k	nowledge, dea	th occurre	ed at the tim	e, date an	d place, and	d due to the	e cause(s)	and manner a	as stated.
	To the H within 24 To the F complete	ledi	one)		and mar	ner stated.	TILLION LING OF II				(11 00001100	at the time			
\	To To Con	Σ	29b. Signature and	title of certifier					9c. License! ر ـــــ (د						nth, Day, Year)
7			150	hang					KES	-00	0		5	11910	6
	6+1		~ :	ess of person who o	ompleted cau	se of death (It	tem 23a) (Type	, Print)	1		Rill		,	10 7	7711
*	Sta	te.	Steve 31. Date filed (Mon		9 7	790 E	nature	W.	4VEU	ue	Dall	men	cr	10 21	CLT
.,	Registi			5 2006	Seg. Sec.	. 18	South	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Machado Luces Josefa 2006 March 15, 2:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Prince George's Clinton If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Hours 1 □ M 2 🛱 F 86 Trinidad & 265-13-7937 Director Dec. 14, Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28s-f show permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23a or 28s-f ehow amy njury or other traumatic event, the Medical Examing must be notified at once. 1 ☐ Yes 2 X No Maryland Prince George's Ft. Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7202 Loch Court 20744 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status ☐Yes 2 🛣 No fYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2012 No Specify: Specify:Hispanic Ā 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Catering 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Jacinto Luces Desideria LaCua 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam Machado-Cooper / Daughter 7202 Lock Court Ft. Washington, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 03/19/2006 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons Examine or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate 2□ No 1 Yes 2 🖾 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 ☑Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No iours after death.

nersi Director: A
filled in by the fu death. investigation 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funersi 29a. Certifie XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa MD 7700 Old Branch Avenue C101 Clinton, Maryland 20735 31. Date filed (Month, Day, Year) . Registrar's Signature State MAR 2 1 2006 Registrar

			For State Registrar	State of M	laryland		rtment of H		d Mental Hy	giene	6	10624
	Physici /Medic	cal	1. Decedent's Name (First, Middle, La Valey & Middle, La 4a. Fecility Name (If not institution, gir	COWLL	l)		4b. City, Town, or	Location of De	2. Date of De Month 3	Day	Year 2006 of Death	3. Time of Death 3. 50 pm
	Examir Funeral Director	ier	Springbrook Nur Center 5. Social Security Number 6.	sing & Rel	nabili ge (In yrs. Ia 93			er Spri	Irs. 8. Date of Bir	th y, Year)	ontgom 9. Birthple Count	ece (State or Foreign
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Montgo 10e. Street and Number	mery		Town or Loc	Spring 10f. Zip Code			10g. Citizen of	10	0d. Inside City Limits
p-0036	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or Itams 23a or 28a-f show event, tre Medical Examinat must be motified at	by Funeral Director	12325 New Hamps 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Amed Forces 1 — Yes, 2 R If Yes, Give Year or Dates	t Ever in U.S ? No	1	209		(Specify Yes or No erto Rican, etc.)	United	Stat. ce - America ck, White, e	es an Indian,
2121	led within 72 lygiene her than "nai ht, the Medic	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, Las	ade completed) College (1-4oi	r 5+)	(Give I life. D	ent's Usual Occup kind of work done of OO NOT use retired Stered N	during most of () urse	working Name (First, Middle	16b. Kind of B St. El Hospit Meiden Suman	izabe al	
yiand	ould be f Mental P arkad of	To Be	William Step	henson				Rebe	cca		(unk	nown)
baitimore, mar	permit. Pages 1 and 2 should be fi Department of Health and Mental In- Important: If itam 27 is marked of any injury or other traumatic even		19a. Informant's Name/Relationship David Bush (Son 20a. Method of Disposition 1) □Removal from Stat	9	509 Mace of Disposemetery, cremontico	ontromer intion (Name of atory or other place National Name and Addres No. Hor	y Stree Mar Cemete ss of Facility ton Cou	ch 20,200 cry	Laurel 20c. Location 16 Quantic	Mary City or Tov	land 20707 wn, State rginia
8/60,	Physician /Medical Examiner stee percented stee stee stee stee purel-transit	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Myocar Due to (or a b. Multi Due to (or a	rdial s a conseque	Infarcence of): Failuence of):	tion	g, such as care	diac or respiratory a	rrest,		Approximate interval Between Onset and Death 2 hrs.
O. Box 6	at the death certificate by the attending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetel o	death 3 🗌	Ectopic pregnancy Other (specify)				ate of deliver	ry Day Year
cords, P.	law requires that as been signed by 2 should be deta	by	Part II. Other significant conditions Diabetes Mellit	-	but not resul	ting in the ur	derlying cause giv	en in Part I.		tobacco use con Yes 2 X No	tribute to the	ne cause of death? ably 4 DUnknown
паі несог	The ate ha	Completed	Dementia						1 ☐ Yes	psy ormed? 2 X No		psy findings available npletion of cause of
>	Physician: Trust certificate ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpa	tient 2 🗆 E	R/Outpatien	3 DOA Oth		Death (Check only g Home 5 Res		ner (Specify	·/
sion of	ling After	atlon: T	27. Manner of Death 1 Natural 2 Accident 5 Pending investigation		jury Jay Year)	28b. Time of Injury	28c. Injun Wor M 1 🗆	yat k? Yes 2 □ No		how injury occur		
Division	i Site	Certification:	3 Suicide 6 Could not 4 Homicide determine	4 280. Place of I	njury - At hon etc. (Specify)	ne, farm, stre	et, factory, office			Street and Numi wn, State)	ber or Rural	l Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exa	hysician: To the bes miner: On the basis and manner:	of examination		estigation, in my o	pinion, death o		date and place,	and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier Adual	R. Co	U.	•	29c. Licens	GO9		310.		
2			30. Name and address of person who Raman R. Tuli,					uite 20	2;Gaithei	sburg,M	aryla	nd 20878
	Sta Regist	ate = rar	31. Date filed (Month, Day, Year) MAR 2 1 200		strar's Signatu		B					

DHMH 17 Rev 1/2001

			To State Registrar	State of Man		artment rtificate				Reg. No	Hun	106	25
	Physici /Medi	cal		, K, r	Moses	45 675	-		2. Date of De Month	Day 16	12006		of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give VC1 Shington A 5. Social Security Number 6. Se 214-94-6284	duentist 1	n yrs. last birthday) Yrs.	To	1 Year	Cation of Dear	8. Date of Bird	th	County of Death Mentge 9. Birth Con Ind	inplace (State	or Foreign
	D D	or	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or Lo				00/10/1	. 700	THO	10d. Inside	City Limits
	with the N 3a or 28a-	Funeral Director	Maryland Montgome: 10e. Street and Number 7620 Maple Ave.	су	Silver S	10f. Zip	Code 20912			10g. Cit	izen of What Co	untry?	
036	be filed within 72 hours after deeth with the Maryland stal Hygiene. Id other then "neturel", or iteme 23e or 28e-f ehow event, the Medical Exeminar must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:			ent of Hisp ify Cuban,	anic Origin? (S Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	-	14. Race - Amer Black, White Specify: Ind	e, etc.	
21215-0036	within 72 ho ene. then "netur he Wedical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	dent's Usua kind of wor DO NOT us Pastor	k done dur e retired)	on ing most of wa	rking		ind of Business/l	ndustry	
Maryland 2	should be filed within od Mental Hygiene. I marked other then umatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) Jacob C. Moses			ascor		_	me (First, Middle, argaret	Maiden	Sumame)		
	and 2 state of the contract of	0.8	19a. Informant's Name/Relationship (T) Anne Pingho/Grando	laughter	12008	Grea	t Ela		otomac,	MD 2	0854		
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition ↑□ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	Removal from State	20b. Place of Dispondentery, creating	matory or of coln C	em.		Date 9/2006 rt Linco	Bren		MD	
Ba	permit. Depertr Imports eny in		23a. Part 1. Enter the disease, or comp	lily	34	01 B1	adens	burg r	d. Brent	wood			ato
760,	death certificate be executed Ex Wedical Gentlending physicien and dor use as the burial-transit	ilcal Examiner	Shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the conditi	onsequence of): tive He onsequence of):	art	Failu	e				Interval B Onset and	
.O. Box 68	at the death certifical by the ettending phi tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic pre ⊒ Other (spe					23d. Date of deli Month	very Day	Year
rds, P.	The law requires thet the set has been signed by the page 2 should be detache	ρ	Part II. Other significant conditions co	ntributing to death but n	not resulting in the u	inderlying ca	ause given	in Part I.		obacco u Yes 2	use contribute to	the cause of	
of Vital Record	: The law recete has be page 2 sho	Completed	Acute Renal Hypertension	failure					24a. Was autor perio 1 □ Yes		death?	opsy finding ompletion of 2 \(\text{No} \)	s available cause of
of Vit	Physicien: Th this certificate ral director, pag	To Be	1 165 2 NO		2 ER/Outpatie		A Other:	4 Nursing I	ath <i>(Check only c</i> Home 5 ☐ Resid	dence		ity)	
Division o	ttending death. ctor: After / the fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day You		М		t s 2 □No	28d. Describe I		ry occurred and Number or Ru	ra <i>l Route N</i> u	mber.
Ö	spital or ours afte serei Din filled in I		4 Homicide determined 29a. Certifier (Check only 2 Madical Exam)	building, etc. (Specify)	h occurred a	at the time	date and plac	City or Tox	m, State) and manner as	hateta	
	To the Hos within 24 h To the Fur completely	Medical	COL Singeture and title of continos	nar: On the basis of ex and manner stated	1.	200	License n	umbor		:30d Del	to signed (Mageth	Day Vand	
R	(2)		30. Name and address of person who c	SEAN Sompleted cause of deat	SAEDI h (Item 23a) (Type,	Print)	D-	60 55 60 55	305 5	11/10	Sociae	20	106
	Sta Regista		SCAN S Saed, N 31. Date filed (Month, Day, Year) MAD 2.1 2006	2. Registrar's	Signature		HVE-	, Juine F	000/01	11407	-r"J/	1210 2	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** James William McConnaughhay March 19 2006 Ам 9:40 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare Spa Creek Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 12, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours XXM 2□F 90 514-40-7015 Yrs. 1916 Kansas Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ?? is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Maryland Anne Arundel Annapolis 1XX es 2 No Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 523 Horn Point Drive 21403 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Maulical Examinat once. 1 XYes 2 □ No If Yes, Give Year or Dates: 1939–66 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Captain U.S. Navy 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be E. Ray McConnaughhay Anna Ethyle Cullison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norma E. McConnaughhay/wife 523 Horn Point Drive Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ft. Lincoln Crematory 3/21/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Panera Swice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cartionyouth **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner nding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ģ in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 3 Probably 4 Unknown cate has been sig ; page 2 should b 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the 1 after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintened a state.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dank Drue Chesh, MD 21619 31. Date filed (Month, Day, State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene; For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 18 2006 11:54 AM Sullivan March Hazel Moore /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Smithsburg
If Under 1 Year | If Under 24 Hrs. 11504 Orange Blossom Court Washington Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs. 079-09-6022 88 1917 Director New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ehow empty injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10h Count 1 ☐ Yes 2 ☑ No Directo Maryland Washington Smithsburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 11504 Orange Blossom Court 21783 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: White 1 ☐ Yes 2 No Specify: Specify: þ 3 ₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Real Estate Agent 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lawrence Sullivan Jenny Grogan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11504 Orange Blossom Court Smithsburb, Maryland Sheryl M. Rudden / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 27, 1 ⊠Burial 2 □ Cremation 3 □ Removal from State 2006 Cheltenham Vet. Cem. Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike Frederick, Maryland 21702 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) month **Physician** h /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner sate has been signed by the attending physiclan and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes ONERS 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No this certificate has h41036(x1 al or Attending Physician: After this certification, I Be referred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home SPResidence 6 Other (Specify) 1 Yes 25 Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation neral Director: A filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year, D16428 n who combleted cause of death (Item 23a) (Type, Print) Frederick, Maryland 21701 Casper Cline, M.D 300 W. Ninth Street 31. Date filed (Month, Day, Year)

MAR 2 2 32. Engistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

			State of Maryland / Department / Department / Department / Department / Department / Department	artment of Health and M rtificate of Death	lental Hygien	UUU	10628		
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month D March 22,	ay 2006 Year	3. Time of Death		
	/Medic Examin	al	Albert James Joseph Myers, Sr. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death	3:42 A M		
	Examin	er	Kline Hospice House	Mount Airy		Frederick	ζ		
	Funeral Director		5. Social Security Number 6. Sex 1 DM 2 F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea.	r) _ Cou	place (State or Foreign intry) nsylvania		
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits		
	death with the Maryland rms 23a or 28a-f show	tor	Maryland Frederick Thurmont				1 ☐ Yes 2 🖔 No		
	ith the or 284 is not	Direc	10e. Street and Number	10f. Zip Code		itizen of What Cou	intry?		
	s 23a	rail	6812 Blacks Mill Road	21788	USA	14. Race - Ameri			
	ter de Item	Funeral Directo	1 □ Never Married 2 □ Married 1 □ Yes 2 □ XNo	Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	, etc.		
2-003p	al, or	by	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify:Whit	ce		
<u>ئ</u>	72 ho	Kind of Business/Ir							
7	within ane. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)		nstructio	nn.		
N D	The state of the s								
yland	uld be f fental h rked of tic eve	To B	Francis Myers	Catherine	e Wetzel				
Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat; or Items 23a or 28a-1 show amy origin: or other traumatic event. It is more in a fee inclined at Once.	i		ng Address <i>(Street and Number or Rur.</i> A Rocky Ridge Road					
altimore,	es 1 a of Hea fitern rothe		20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State	osition (Name of matory or other place) March	n 20c.	Location - City or T	own, State		
Ĕ	Pag ment tant: I		`4 □Donation 5 □Other (Specify) Chesapeak	ce Crematory 200		tsville,			
Ra	permit Depar Impor any in		Devel & Helle MO1251 P	2 Name and Address of Facility Coing Home Crematic Severly L. Heckroti	te. P.A. C				
	Physician /Medical Examiner			ter the mode of dying, such as cardiac		4	Approximate Interval Between Onset and Death		
où,	cate be executed oblysician and the burial-transit	i Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):						
09/8	icate b physic s the b	dicai	d						
O. Box 6	ath certif attending for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	very Day Year		
ds, P.	w requires that the de been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			the cause of death?		
Hecords,	The larate has	Completed			24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of		
Vital H	yaician: This certificate director, pag	Be (25. Was case referred to medical examiner?		h (Check only one)		1400-00		
0	Physi this o	T.	1	The second secon	ome 5 Residence 28d. Describe how in		House		
O	ding Ph th. : After th funeral	tion	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		a., 555455			
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illied in by the funeral director,	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street: City or Town, Sta	and Number or Rui ite)	ral Route Number,		
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.						
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number 1) 4 / 8 6		Pate signed (Month)	, Day, Year) 22,2006		
94	5 E.G.		30. Name and address of person who completed cause of death (Item 23a) (Type, Kanan Hudhud; no 46 B. Thomas	Print) To huran Dr. Free	deick , w	D 2170	2		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2. 2 2006 32. Registrar's Signature	barli	*		<u> </u>		

			licase						Liliaule A	-		_		
			1 For State	State of Ma	arylan		artmen <i>rtificat</i>			Mental H	(UUD	1062	29
			Registrar 1. Decedent's Name (First, Middle, L.	anti			rincan	e UI L	calli	2. Date of D	Reg. No		0. T	
3	Physici	an								Month	Day		3. Time of I	
	/Medic			Minor			1			March			2040	M
4.	Examin	er	4a. Facility Name (If not institution, git Gladys Spellman	,					ocation of Deat	h		County of Dea		
15						last birthday)	Lando		If Under 24 Hrs	8. Date of E		ince Ge		
Ι,	Funeral Director		247-36-6587	1 ☐ M 2 【XF		9 Yrs.	Months		Hours Min.	(Month, I	Dav. Year)	126 Sout	thplace (State or ountry) th Caro1	roreign
- 1			Usual Residence of Decedent			,	1			pury r	0, 13	20 pour	II Calui	IIIa
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City	y Limits
	Mar	tor	Maryland Prince	George's	Land	over							1 🗆 Yes	2 X No
	n the	irec	10e. Street and Number				10f. Zip	Code			10g. Cit	zen of What Co	ountry?	
	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or items 23s or 28s-f show event, I're Medical Evarding must be notified at	Funeral Director	1615 Belle Haven	Drive			2078	35			USA			
	dea	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.	S. 13.	Was Deced	dent of His	panic Origin? (S , Mexican, Puer	Specify Yes or N	No-	14. Race - Ame Black, Whit		
9	or it	F	1 Never Married 2 Married		No		1 ☐ Yes			,,				
8	urel',	d by	3 🕅 Widowed 4 🗌 Divorced	Year or Dates:								Specify: Bla		
Maryland 21215-0036	"nat	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	==	16a. Dece (Give	dent's Usua kind of wor	al Occupat	ion uring most of wo	rking	16b. K	ind of Business	/Industry	
2	withir ene. then	ш	Elementary/Secondary (0-12)	College (1-4or 5		Homema		se retired)			Oran	Home		
2 2	Hyginther ther	ŏ	17. Father's Name (First, Middle, Las	it)		nomeme	ikei		18. Mother's Nar	me (First, Midd				
an	d be ental ked c	To Be	Parks Brewer						Eliza Wa	0 1 Ir one		•		
2	shound Minari	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address		nd Number or Ru		ber, City o	r Town, State,	Zip Code)	
	nd 2 alith a 27 is r trau		Billy D. Brewer/s	son		1615	Belle	Have	en Drive	e Lando	ver.	MD 2078	35	
ē,	s 1 a f Hea itam othe		20a. Method of Disposition		20b. P	lace of Dispo emetery, crea				Date		cation - City or		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dep. Itment of Health and Mental Hygiene. Important: If item 27 ie marked other then "naturel", or items 23s or 28a-1 ehow any injury or other traumatic event, the Medical Examinat must be notified at once.		1 Burial 2 Kremation 3 4 Donation 5 Other (Spec	☐Removal from State ::ify)		sapeak			1101	ch 23, 006	Pole	ov.411	Manual a	
=	ourtm Sortm Vinju		21. Signature of Funeral Survice Lice	and the same of th	Gne	22	2. Name an	d Address	of Facility				Maryla	na
m			1 Bare JK	Holatt	MO12	51 Be	ung H	iome (Cremátio Heckroti	on Serv	ice Cla	P.O. Bo rkewill	x /84 e, MD 2	1020
			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	mplications that caused		n. Do not en	ter the mod	le of dying,	such as cardia	c or respiratory	arrest,	LKSVIII	Approximate Interval Betw	
	Physician		Immediate Cause (Final disease or condition										Onset and D	eath
П	/Medical		resulting in death)	a. <u>Renal Fa</u> Due to (or as									4 mont	ns
	Examiner		Conventially list annulities	_{b.} Hyperten	sion								20 year	15
	D =	ner	Sequentially list conditions, if any, leading to interrediate cause. Enter Underlying Cause (Disease or injury	Due to (ur as										
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
760,	se exe		resulting in death) Last	Due to (or as	a consequ	uence of):								
	m × m	dicai		d	_									
x 68	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	Med	IF FEMALE:	000 16.000 0.000000									***************************************	
Bo	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3	Ectopic pr					23d. Date of de Month		ear
o.	the de	ysic	1 ☐ Yes 2 🎇 No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time or de	eath 5L	Other (sp	еспу)						
Division of Vital Records, P.O. Box	that the de ned by the a detached f	by Physician/M	Part II. Other significant conditions	contributing to death br	ut not resi	ulting in the u	nderlying c	ause giver	n in Part I.	23e. Dio	tobacco u	ise contribute to	the cause of de	eath?
ds,	w requires that been signed to should be det	d b	cerebrovascular a			_							robabiy 4 ▼]Ur	
Ö	v requ	ete							-	24a. We				
Be e	he lay	Completed	sepsis							aut	opsy formed?	prior to death?	utopsy findings a completion of cal	use of
a	n: Ti ficate or, pa		OF Mon area referred to the distal							1 ☐ Yes	2× No		2 No	
5	certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital:	-1 00	50/0-1		Othor	26. Place of Dea					
ō	Attending Physician: The lav r death. sctor: After this certificate has by the funeral director, page 2	$\vdash \vdash$	27. Manner of Death	1 Inpatie	ry	ER/Outpatier 28b. Time o		//	4 KM IAMISING F	28d. Describe			cify)	
o	th. : Afte	tio	1X Natural 5 ☐ Pending 2 ☐ Accident investigate	(Month, Day	y Year)	Injury	м	8c. Injury a Work? 1 □ Ye	es 2 🗆 No			•		
S	or Attend after death Director: / in by the f	Hice	3 ☐ Suicide 6 ☐ Could not	d 286. Place of Inju	ury - At ho	me, farm, sti	reet, factory	, office					ural Route Numb) <i>01</i> ,
	alor s afte l Dire	Certification:	4 Homicide determined	building, etc	c. (Specify	<i>'</i>)				City or T	own, State)		
	To the Hospital or Al within 24 hours after o To the Funeral Direct completely filled in by		29a. Certifier 1 XCertifying P	Physician: To the best of	of my kno	wledge, deat	h occurred	at the time	, date and place	e, and due to th	e cause(s)	and manner as	s stated.	
	he Hin 24 he Fi	edicai	one)	aminer: On the basis of and manner sta	examina ated.	lion and/or in	vestigation,	, in my opii	nion, death occu	urred at the time	e, date and	place, and due	to the cause(s)	
	To the within 2 To the I	Σ	29b. Signature and title of certifier	hound		MO	290	License		610	29d. Dat	e signed (Mont	Day, Year)	
2				9/		(-10	1	16	2731	40	0	120/	00	
X	E.G.		30. Name and address of person who		-									
	THE REAL PROPERTY.		Revathy Murthy M.				Land	over,	, MD 207	785				
1	Sta Registr		31. Date filed (Month, Day, Year) MAR 2.3	32. Registra	ars Signa		hands)	į.						
200	100			W 40 KINN		Accept Accept	THE PERSON NAMED IN	_						

		•	1 - For State Registrar	State of M	aryland / D		artment of rtificate o				giene Reg. No.	06	106	30
	Physicia	an	1. Decedent's Name (First, Middle, La	st)						2. Date of Dea Month	ith Day	Year	3. Time of	Death
	/Medic		Milton Martin							March		2006	7:30	P M
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, Town					inty of Death		
			3701 Internationa 5. Social Security Number 6. S		D Z 0 ge (In yrs. last birth	ndav)	Silver If Under 1 Ye		r 24 Hrs.	8. Date of Birtl		tgomer	place (State o	or Foreign
-	Funeral Director			15 M 2□F 93		rs.	Months Da	ys Hours	Min.	8. Date of Birtl (Month, Day Nov. 30	, Year) 0. 191	Cou	ntrv)	
	ט		Usual Residence of Decedent				1							
	show	-	10a. State 10b. County		10c. City, Town								10d. Inside C	ity Limits 2 ∐ No
	he M	ecto	MD Montgom	ery	Silver	Sp					10- 011	-4115		
	a or	Funeral Director	3701 Internationa	1 Drive #	526		10f. Zip Cod 2090				U.S.A	of What Cou	nuyr	
	heath	eral	11. Marital Status	12. Was Decedent	Ever in U.S.	13.			rigin? (Sp	ecify Yes or No-		ace - Ameri	can Indian,	
S	or Iten	듄	1 ☐ Never Married 2 🔀 Married	Armed Forces' 1 ☐ Yes 2X	?					ecify Yes or No- Rican, etc.)		Black, White,		
ğ	72 hours after death with the Maryland natural', or Iteme 23e or 28e-f show dical Exandrar must be notified at	b b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		_	1⊡Yes 2⊠i	No Specify	/: 		Spe	White	e	
2-0	72 h 'natu	Completed	15. Decedent's E (Specify only highest gra			(Give	dent's Usual Oc kind of work do	ne during mo	st of work	ing		f Business/In		
121	within sne. than	d m	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use re cist	tired)			Dont	of No		
2	filed which there is the the there is the the the there is the there i	e Co	17. Father's Name (First, Middle, Last,		Fily	SI	CISL	18. Moth	ner's Nam	e (First, Middle,		of Na	vy	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Examination until enouthed at ones.	m	Joseph Martin					Celi	а Ве	ergolofs	ky			
ary	shous s mai		19a. Informant's Name/Relationship (-			al Route Numbe	-			
Σ,	and and m 27		Charlotte M. Mar	tin-Wite						526 Sil				06
ore	or of	1 1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	,		sition (Name of matory or other	place)		Date	20c. Locatio	on - City or T	own, State	
E m	rt. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specif21. Signature of Funeral Service Lice)		Mt. Leb				3-19		delph			
Ba	Depa Impo any i		Torrald C.	Dtots	Times	5	1170 R	ockvil	le P	rg Memor ike Roc	cial C ckvill	hapels	, Inc. 10852	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death. Do no	ot ent							Approximat Interval Bet	ween
	Priysician		Immediate Cause (Final disease or condition	Cancer	of Pancr	ea	s						Onset and Months	Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence o	f):								
b		_	Sequentially list conditions,	b. Due to (or as	s a consequence o	f\·							_	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	20010 (0. 20	2 201100 4251100 0	.,.						1		
Ć.	be executed icien and burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as	s a consequence o	f);								
8760,	cate be executed physicien and the burial-transit	cal	(d										
9		an/Medical	JF FEMALE:											
Вох	death certif e attending ed for use a		23b. Was decedent pregnant in the past 12 months?		2 Fetal death		Ectopic pregna					Date of deliv Month		Year
o.	0 0	Physici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	at time of death	51	Other (specify	<i></i>						
٥	that the		Part II. Other significant conditions of	contributing to death	but not resulting in	the u	nderlying cause	given in Part	1.	23e. Did to	bacco use c	contribute to t	he cause of o	leath?
rds,	requires that the een signed by th nould be detache	ed by								1 🗆 Y	es 21X No	o 3 ☐ Prot	bably 4 🗆	Jnknown
Vital Record	> 0 75	Completed								24a. Was		b. Were auto	opsy findings	available
Ä	e h age	E O								autop perfor 1 Yes	med?	death?	mpletion of c 2□ No	ause or
ita	certificat	Be	25. Was case referred to medical examiner?							h (Check only or				
of V	Physicien: this certific	၉ ့	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpati						ome 5X Resid			fy)	
		ertification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Ti ay Ye <i>ar)</i> In	me o jury	1	njury at Work? I □ Yes 2 □		28d. Describe h	ow injury oci	curred		
Division	or Attending after death. Director: After in by the fune	licat	2 Accident investigatio 3 Suicide 6 Could not b	e 200 Place of In	jury - At home, far	m, str				28f. Location (S	treet and Nu	umber or Run	al Route Num	ber.
Š	in Diffe	Certi	4 Homicide determined	building, e	tc. (Specify)		,,			City or Tow	n, State)			
	d 4 h	edical (nysicien: To the best niner: On the basis of and manner s	of examination and									5)
	To the within 2. To the I complet	M	29b. Signature and title of certifier					ense number				gned (Month,	Day, Year)	
)	20		MIKON	expr			D098	34			3/17/20	UU6		
	-		30. Name and address of person who Barry N. Rosenbau	m, MD.,P.	A. 3720	Fa	rragut	Ave. K	ensi	ngton, M	D 208	95		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 2	2006 32. Togisi	rar's Signature	A	parte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene] 1 - For State Registre Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Day Month Vear **Physician** 11:37_P^M Viola March 17 2006 Laura Moran /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 7820 Friends Creek Road Frederick Emmitsburg 8. Date of Birth (Month, Day, Year) June 21, 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days 398-36-8686 1 □ M 2 🗓 F 72 1933 Wisconsin Director Usual Residence of Decedent Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28e-1 show any injury or other traumatic event, the Medical Exercited for all pages. 1 ☐ Yes 2X No Director MD Frederick Emmitsburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7820 Friends Creek Road 21727 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 2 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Herman Marklein Erna Willey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7560 Damascus Road Gaithersburg, Md. 20882 Anne-Marie Winnard (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 22, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Barnesville Barnesville, Md. 2006 '4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licens ustis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10 East Deer Park Dr. Gaithersburg, Md. 20877 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician 3 Months Acute Leukemia /Medical Due to (or as a consequence of): Examiner Chronic graulocytic Leukemia 4 Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed Due to (or as a consequence of): attending physician Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subsete \text{No} \) 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Atrial fibrillation Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1 ☐ Yes 2**X** No Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 1 ☐ Yes 2 XNo 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: al or Attending P after death. After 5 Pending investigation XNatural 1 ☐ Yes 2 ☐ No М 2 🗌 Accident 6 ☐ Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier To the within 2 29c. License number 29b. Signature and title of certifier 014626

State Registrar

10

raul

Greg

MAR 2 2 2006

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kaux

32 Registrar's Signature

			For State Registrar	State of	Marylar	-			leaith ar Death	nd M		giene Reg. No.	06	10632
	11.00		1. Decedent's Name (First, Middle	, Last)							2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medic		Charlotte	Elizal	beth	McC	art				Marc	n 20, 6	2006	8:33 AM
	Examir		4a. Facility Name (If not institution	, give street and numb	oer)				Location of				ity of Death	
		1000 m	SALISBURY REHA				11.11		RY, MD.				OMICO	
	Funeral		5. Social Security Number	6. Sex 7.		last birthday, Yrs.	Months	Days	If Under 24 Hours	Min.	8. Date of Birt (Month, Da	n y, Year)	Cou	
	Director		146-22-8616 Usual Residence of Decedent	-	78	113.		l			3/10/	1928	New	Jersey
	land		10a. State 10b. County		10c. Ci	ty, Town or L	ocation							Od. Inside City Limits
	the Maryland 28s-f ehow	JO.	Maryland Wico	mico	S	alisbu	irv							1 Yes 2X No
1_	179 The	rect	10e. Street and Number					p Code				10g. Citizen o	f What Cou	ntry?
7,	ith with 23a or	Ö	8244 Robinho	od Drive				218	304			U	ISA	
7	after death with	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U	J.S. 13.	Was Dec	edent of H	ispanic Origi	n? (Spe	ecify Yes or No Rican, etc.)		ace - Ameri	
()	or Its	Fur	1 Never Married 2 Marr	Armed Force 1 Yes 2 If Yes, Give	I No		1 ☐ Yes			Puerto	nican, etc.)		lack, White,	eic. iite
1) C	hours after tural; or ite	by	3 Novidowed 4 Divorced	Year or Date	es:		1 1 1 1 1 1 1 2	215 NO	Specify.			Spec	sily: WI	
5	2 2	Completed	15. Decedent (Specify only highes			16a. Dece (Give	e kind of w	ork done	during most o	of worki	ng	16b. Kind of	Business/In	dustry
2	E 2	idu	Elementary/Secondary (0-12)	College (1-4	lor 5+)		DO NOT		1)			Dom	estic	
21 5	000	ပိ	12 17. Father's Name (First, Middle,	-		Hou	sewi:	te	19 Mothor	c Nome	(First, Middle,			
4 5	be find the property of the pr	To Be	Richard Brady	Last)					Anna		heehan	Maiden Sum	arne)	
大	should be nd Mental marked o	မို		nia (Timo Briet)		10h Mail	ina Adden	o /Stroot			I Route Numbe	or Cibror Tou	m State 7ii	Code
Charlotte	1 and 2 should be filed with the should be filed with the should be filed with the state of the should be		19a. Informant's Name/Relations Ann Marie Nol		.		•				Salisbu			
5	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition	an/daugnte	Contract of the second	Place of Disp cemetery, cre					ate	20c. Location		
S S	00		1 Burial 2 Cremation		ale									
4	permit. Page Depertment Important: If eny injury o		4 □Donation 5 □ Other (S			lisbur					/06	Salis		
	Depermit. Depermit. Import	1	000/	Licensee	CF	FSP C	10110 501	Snow	runera	59 ·	ome Pro Salisk	oiessio	nal A	ssociation
			23a. Part1. Enter the disease, or	complications that rai	used the dea	th. Do not en							220	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on each	ch line.)	1		1.					Interval Between Onset and Death
•	Physician /Medical		disease or condition resulting in death)	a. Due to (b	r as a consec		-7	1	cont	0				lan
	Examiner			500 10 30	1	a . 4			. (5)				24	0 2 0
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	r as a ponsed	quence of):	- Lung	76						
	be executed sicien and burial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	S .	1								-	
_	exec an an rial-tr	Exa	resulting in death) Last	Due to (o	r as a consec	quence of):								
0228	ate be nysicie he bui	dical		d										
U	as at	(d)	15.55.44.5											
2	eath certific attending p for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregn		□Ectopic	pregnancy	,				Date of deliv	•
	dean ne att	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No		nt at time of		Other (,	Month	Day Year
0	at the de	Phy	9 Unknown								00. 5:44			h
0	The law requires that the death certificate be executed the best been signed by the attending physicien and bage 2 should be detached for use as the burial-transitions.	þ	Part II. Other significant condition	ns contributing to dea	ith but not re	sulting in the	underlying	cause giv	en in Part I.			obacco use co Yes 2.⊡—Mo	_	he cause of death?
7	v requir been s	Completed									-	-		
Č	taw taw 12 st	pie									24a. Was auto	an 24l	b. Were auto	psy findings available impletion of cause of
٥	The lav	Son									1 ☐ Yes		death? 1 ☐ Yes	2 ☐ No
2	certificel	Be	25. Was case referred to medica examiner?							of Death	(Check only o	one)		
4	Physicia this cert at direct	2	1 ☐ Yes 2 ☑ No			ER/Outpatie			4 LANUIS		me 5□Resi			(y)
2	Attending Physician: r death. ector: Attenthis certifice by the funeral director, i	 	27. Manner of Death 1 ☑Natural 5 ☑ Pendir	28a. Date of (Month)	Injury , Day Year)	28b. Time Injury		28c. Injur Wor			28d. Describe	how injury occ	urred	·
- 2	Mtendi death. ctor: A y the fu	cati	2 Accident Investig			1	М		Yes 2 □ N		004 1	C1		
skycoso IciV) so noisivio	or Attendent after deat I Director:	Certification:	4 Homicide determ	200. Flace	of Injury - At h g, etc. (Speci	nome, farm, s ify)	treet, facto	ry, office			City or To		mber or Hun	al Route Number,
_	Hospital 24 hours a Funeral C	ပိ	29a. Certifier 1/Q-Certifyir	ng Physician: To the b	nost of my kn	owledge dea	th course	d at the tir	mo date and	place	and due to the	causo(s) and	mannar ac .	tatad
	24 ho Fun etely	edicai		Examiner: On the bas and_manner	sis of examin									
	To the Hospital or within 24 hours af To the Funeral D ' completely filled in	Me	29b. Signature and title of certifle	——————————————————————————————————————			2	9c. Licens	e number			29d. Date sig	ned (Month,	Day, Year)
	10,		> inth.					800	93	4	9	7/5	181	
		7	30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type	, Print)	1 6	1-1	-		100	/ 00	
	'		WILLIAM ROBINS					ISBUF	RY, MD	. 2	1804			
	Şt	ate	31. Date filed (Month, Day, Year)		gistrar's Sign		_							
1	Regist		MAR 2	2 2006		K.	Coast.							

DHMH 17 Rev 1/2001

			For State	State of Marylar		artment of H			4000	10633
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	lilicate of	Dealli	Reg.	No.	3. Time of Death
	Physicia	an	Delvin Allen						Day Year	
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat	h	4c. County of Dea	ath
87	Examili	CI.	SACred Meak	of Klaspita	1	Cumb	eplano		AlleGA	ANV
	Funeral		5. Social Security Number 6. Sex		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bi	rthplace (State or Foreign ountry)
В	Director		234-30-1400	^{™ 2□ F} 68	Yrs.	Midital Buyo	1,0010	July 1,		etz, WV
	and **	+	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Manyl f eho	ō	WV Mineral		Keyser					1 ☐ Yes 2 🙀 No
	1 the	Director	10e. Street and Number		Reyser	10f. Zip Code		10g.	Citizen of What C	Country?
	h with		Rt. 2, Box 214			2672	26		USA	
	deat	Funeral		12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
စ္က	or It	F.	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🔀 No	Specify:		Specify:	
Ö	hours ture!	d by	3 Widowed 4 Divorced	Year or Dates:	162 Dagg	dent's Usual Occup	ention	166	. Kind of Busines	White
7	in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done DO NOT use retired	during most of wo		. King of Busines	a modestry
212	iene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Build:	ing Mgr./	Faciliti	es Mtnc.	U.S. Tre	asury
פ	e filec othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Maid	den Sumame)	
<u>a</u>	Menta Menta	2	Leo Moreland				Halli	le Marie Mo	Daniel	
Maryland 21215-0036	and and les my		19a. Informant's Name/Relationship (Ty					ural Route Number, Ci		Zip Code)
2	feelth m 27 her tr	1	Helen Marie Morel			2, Box 2 sition (Name of	214 Keys		726 Location - City of	r Town State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Exeminar must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ F	Removal from State	cemetery, crei	matory or other pla		March 31	•	
불	it. Pa	Ť	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligens			erland C1 2. Name and Addre			Cumberla	ind, MD
Ba	Depariment of the part of the		Pour Man A	milk				Smith Funer Keyser,		26
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ications that caused the dea						Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	6	Nax-	a Ytern	disco	er		Inset and Death
	/Medical		resulting in death)	Due to (or as a conse	· · ·	, ,)			8
	Examiner		Sequentially list conditions,	b	(sche	5160				20 years
V	sit s	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
٧	xecut and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
8760,	icate be executed physicien and s the burial-transit	dical E		4						
9	ifficate g phy as the	edic		v					1	
Вох	leath certific attending p	Z/N	230. was decedent pregnant	23c. If yes, outcome of pregr 1□Live birth 2□Fet		⊒Ectopic pregnanc	v		23d. Date of d	
о С	o deat	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of 9 Unknown		Other (specify)			Month	Day Year
P.O.	uires thet the de signed by the a Id be detached f	Phy	9 Unknown				on in One I	020 Did tobac	an una anatributa	to the cause of death?
ŝ,	res th	Ď	Part II. Other significant conditions co	nthouting to death but not re	suiting in the u	indenying cause giv	/en in Parti.	1 Yes		Probably 4 Hinknown
5	w require been sign	eted	1/24	fal.					1	
3ec	has the	Completed	1000	1 merrie	- Aus	2 A VC.		24a. Was an autopsy performed	prior to	autopsy findings available completion of cause of
a	iicien: The lav certificate has rector, page 2		pe (I place)	or Mercons	Cod	7.007°	0/ /5	1 ☐ Yes 2 🕰		es 2 No
₹	sicial certi	o Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ott	or.	ath <i>(Check only one)</i> Home 5□ Residence	a 6 □Other (Sr	nacihi)
ō	Phy or this oral d	2:	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o			28d. Describe how i		ochy)
Division of Vital Records,	ath. T: Afte e fun	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		rk? Yes 2∐No			
Vis	er dei	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
ā	rs aft	Cer		, , , , , , , , , , , , , , , , , , , ,		Marie en la companya de la companya		10-14-14-14-1		
	To the Hospital or Attending Physician: The law requires thet the death certific within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending prompted principle in by the funeral director, page 2 should be detached for use as	Medical		sician: To the best of my kr iner: On the basis of examin and manner stated.						
	To the Mithin To the	Me	29b. Signature and title of certifier	0 0 0		29c. Licens		29d.	Date signed (Mo	nth, Day, Year)
	->-0		> 1/2 D.	Child !	W	03	4362	N	narch	28,2006
•	. 0		30. Name and address of person who c	ompleted cause of death (Ite	em 23a) (Type,	, Print)		verland		
	10			olm 924	SEtOI	V DRIVE	, Cum	berland	imo a	21502
	Sta		31. Date filed (Month, Day, Year) APR 0 5 2	32. Sgistrar's Sign	nature	redi				
	Registi	aı	0 0 2	A STATE OF THE STA	Sa 13					

DHMH 17 Rev 1/2001

		•	For State	State of Mar		partment of F Certificate of			a 001	5 10634
	4		Registrar 1. Decedent's Name (First, Middle, La	ıst)		ertificate of	Dealii	2. Date of Deat	eg. No. h	3. Time of Death
	Physici		4 4 5 694					Month © 3	Day Ye	6 18:32 M
1	/Medic Examin		4a. Don Michael Milles		. []		r Location of Death		4c. County of E	
			Sacred Hea			Cumbe			Alleg	
	Funeral		5. Social Security Number 6. :	Sex 7. Age	(In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		34	"		24-May-	1921 N	<u>Maryland</u>
	yland		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	Ba-f-	ctor	Maryland Alleg	anv	Frostburg					1 X Yes 2 □ No
	vith th	Director	10e. Street and Number	hington Street		10f. Zip Code		1	0g. Citizen of Wha	t Country?
	seth v	erai		12. Was Decedent Ev	(er in II S	21532- 13. Was Decedent of H If Yes, specify Cub.	Hispanic Origin? (Sp	acity Vac or No-	U.S.A.	American Indian,
	tter d	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 Yes 2 □ No If Yes, Give)		an, Mexican, Puerto	Rican, etc.)		Vhite, etc.
5-0036	rel', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	WWII	1 □ Yes 2 P No	Specity:		Specify:	Vhite
2 2	filed within 72 hours after deeth with the Maryland Hygiene. Ather then "neturel", or Items 23a or 28e-f ehow Int, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Do	ecedent's Usual Occup ive kind of work done e. DO NOT use retire	oation during most of work	sing	16b. Kind of Busin	ess/Industry
2121	within ne.	Пр	Elementary/Secondary (0-12)	College (1-4or 5+)	e. DO NOT use retire	d)			
2	filed wi Hygien ther th	ပိ	17. Father's Name (First, Middle, Las.	, 0	ow	ner/operator	18. Mother's Nam	e (First, Middle, M	tavern Maiden Sumame)	
an	ould be i Mental I warked o	To Be					T :11: D	11-		
aryland	to be a	۲	19a. Danis B. Miler e a ionship	(Type, Print)	19b. M	ailing Address (Street	Lillian B	Tank. ral Route Number	City or Town, Sta	te, Zip Code)
≥	and 2 Balth a n 27 ie		Elorence Miller	wife		Washington St		stburg	Marylar	
altimore,	0 0		Plorence Miller 20a. Method of Disposition 1) Burial 2 Cremation 3		20b. Place of D. cemetery,	sposition (Name of crematory or other plan	сө)	Date	20c. Location - City	y or Town, State
Ē	Pages ment of ent: if it		4 □ Donation 5 □ Other (Speci	(y)	Restlawr	Memorial Gar		-Mar-2006]	LaVale	Maryland
Ba	permit Pages 1 al Department of Hea Importent: If item any injury or othe once.		21. Signature of Funeral Service Lice	nsee	1	22. Name and Addre			T 4	ID 01522
	40244		23a. Page. Enter the disease, or con	polications that caused the	he death. Do not		ral Home, 57			
я			affock, or heart failure. List only Immediate Cause (Final	one cause on each line).					Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. ACUI	consequence of)	PIRATORY	1 DISTRE	558 Just	crome	6 days
н	Examiner			ACUT.	Z My	PLRATORY CARDIAL	- Inx	arction		9 0440
		ner	Sequentially list conditions, if any, leading to immediate cause. Foter Underlying	Due to (or as a	consequence of):		U			1 - 13
	ocuted nd transi	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
20	oe execien a	Ē	resulting in death) Last	Due to (or as a	consequence of):					
58760,	licate be executed physicien and s the burial-transit	edical	•	d						
Box 6	certif	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of	delivery
	death a atter	Physician/M	in the past 12 months?	1□Live birth 2 4□Pregnant at ti		3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _	y 		Month	Day Year
0.0	tt the by the tache	hys	9 Unknown	9□ Unknown						
	The law requires that the death certif tte hes been signed by the attending vage 2 should be detached for use as	by P	Part II. Other significant conditions				en in Part I.			te to the cause of death?
ord	w require been sly should k		CLORENARY			<u>C</u>		1 _ Ye	es 2 E/No 3	Probably 4 Unknown
Division of Vital Records,	taw r	Completed	V/4BETES	Mellitus				24a. Was a autops	y prioi	e autopsy findings available to completion of cause of
<u>e</u>	hysician: The law his certificate hes t I director, page 2 s		Renal 3	N Suffice	lency			perform 1 Yes 2		
₹	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		O#	200	th (Check only on		
ō	Phys r this sral di); To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Tim	ie of 28c. Injui	4 Nursing no		ow injury occurred	Specify)
<u>o</u>	ath. r: Afte	atlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigated	(Month, Day`	Ye <i>ar)</i> Inju		rk? Yes 2 ☐ No			
<u>Vis</u>	Atte ar de crecto by th	Certification;	3 Suicide 6 Could not l	28e. Place of Injury building, etc.	y - At home, farm	, street, factory, office		28f. Location (St. City or Town		or Rural Route Number,
ā	ital or rs eft rel Di	Cer		January, stor	(0,000.7)					
	Hosp. 4 hou Funei ely fill	ical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of e						
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical	one) 29b. Signature and title of certifier	and manner state	ed.	29c. Licens	se number	1 91	9d. Date signed (A	fonth, Day, Year)
	Z Z Z S		501	J. M. Carre		D 2	5638		march	19 200/
d	7/10A		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Tu	pe. Print)	0		1 / Wz Coc	11,000
	mrs		SATURNINA CI	JANG M.D.	4BR	pe, Print)	Frost.TE	eury A	larylas	of 2/532
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 0 2	006 32. Augistrar	s Signature	book				

			For State Registrer	State of Ma		Depa		Health an	nd Mental H		006	10635
			Decedent's Name (First, Middle, Last)						2. Date of D		V	3. Time of Death
	Physici		John	Willia	am		McCoy		Month	20.	y Year 2006	1:40 P M
	/Medio Examir		4a. Facility Name (If not institution, give s				4b. City, Town, o	or Location of D		40	. County of Dea	
		•	Cumberland Villa	Nursing (Center		Cı	ımberla	nd		Allega	ny
	Funeral Director		5. Social Security Number 6. Sex 214-09-9393	7. Ag	e (In yrs. last b 84	birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of E Min. (Month, U 03/08/			thplace (State or Foreign ountry) y land
	and *] }	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	e Maryli 8a-1 sho ptiffed a	Director	WV Mineral				Ridgeley	7				1 ☐ Yes 2 📉 No
	th with the 23a or 2	al Dire	10e. Street and Number RR #1 Box 304					5753		US	tizen of What Co	ountry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic avant, I'le Mariful Examination in any injury or other traumatic avant, I'le Mariful Examination in any once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 ☐ I If Yes, Give Year or Dates:	No		Vas Decedent of I f Yes, specify Cub □ Yes 2 1\ No		n? (Specify Yes or Neuerto Rican, etc.)	10-	14. Race - Ame Black, Whit Specify:	
21215-0036	ithin 72 h	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5		(Give life. L	lent's Usual Occu kind of work done OO NOT use retire	during most of	f working	16b. F	(ind of Business	,
C	ygier ygier yarth		10				Laborer	40 14-15-1-	Name (Flora Middle	(- 14-/-/-	Railro	oad
Maryland	2 should be filed withi and Mental Hygiene. Is marked othar then aumatic avant, It s M	To Be		Mastel		McCoy		Mary		Cathe	rine	Stipe
lar	2 sho		19a. Informant's Name/Relationship (Type						or Rural Route Num			
Baltimore, 1	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra ance.		John W. McCoy, II 20a Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R		20b. Place	230 of Dispo tery, cren	E. 50th sition (Name of natory or other pla	Street,	Apt 9-B	20c. L	ocation - City or	NY 13022 Town, State
Ë	Pag ment lant: I		` 4 ☐ Donation 5 ☐ Other (Specify)		Cumbe	<u>erla</u> r	d Cremat	ory 0	3/22/2006	Cu	mberlan	d, MD
Balt	permit Depart Import any in		21. Signature of Fundral Service License	Ellan		1			Adams Far et, Cumb			Home, P.A. 21502
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Co,	ronan	1	er the mode of dyi			arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner).	a consequent		- /					
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on Injury that initiated events	·	a consequenc							
3760,	ate be executed nysician and he burial-transit	cal	resulting in death) Last	·	a consequenc	ce of):						
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal dea		Ectopic pregnand Other (specify)	у			23d. Date of de Month	livery Day Year
ds, P.	uires that signed by	b	Part II. Other significant conditions con	ntributing to death b	out not resulting	g in the u	nderlying cause gr	ven in Part I.		l tobacco		o the cause of death?
Records,	The law requir ate has been si page 2 should I	Completed							ре	is an opsy formed? 2 2 N	prior to death?	utopsy findings available completion of cause of
Vital	stan: artifica ctor,	Be (25. Was case referred to medical examiner?					The second secon	Death (Check only			
of	ding Physiclan: The lav h. After this certificate has funeral director, page 2	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	lospital: 1 Inpation 28a. Date of Injui	ent 2□ER/o iry 28t y Ye <i>ar)</i>	Outpatier D. Time of Injury	28c. Inju	her: 4 \ Nursi iry at irk?] Yes 2 \ No	ing Home 5 Re 28d. Describ			ecify)
Division	Attan ar deat actor: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, et	jury - At home, ic. (Specify)	, farm, str	eet, factory, office		28f. Location	(Street a own, Star	nd Number or R	ural Route Number,
	the Hospital or hin 24 hours afte tha Funaral Dir npletely filled in	Medical C	29a. Certifier XX Certifying Physic (Check only one) 2 Medical Examination		f examination							
	To the within 7 To the comple	Me	29b. Signature and title of certified				29c. Licen	se number		29d. D	ate signed (Moni	th, Day, Year)
~	11			entrus			D33	280		Ma	rch 21,	2006
5	TIVA		30. Name and address of person who co				Print)		-1 1 - 25			
	nds		Sunil K. Gup	20 4	- d- Ci		4	Cumber	rland, MD	21.	502	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 1 200	6 Section	rar's Signature	Jag.	colle					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** CHRISTINE 19 2006 1:22 P M R. MOODY March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery 3116 Gracefield Road, Apt #208 Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 8. Date of Birth Month, Day 10/24/1916 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Days Hours 067-01-0071 89 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if tiem 271s marked other than "natural; or iteme 23a or 28a-f show and injury or other traumatic event, the Medical Examinat must be notified at an injury or other traumatic event, the Medical Examinat must be notified at an injury or other traumatic event, the Medical Examinat must be notified as an injury. 1 ☐ Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3116 Gracefield Road #208 20904 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Leonel Rohan Enez Joline Vernon ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Asma Nuh - Daughter 1016 Merrimac Drive; Silver Spring MD 20903 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Long Island Nat. Cem. 3/23/2006 Farmingdale, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. Myelin T. Wobert 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 years Aortic Stenosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <u>3 years</u> <u>Congestive Heart Failure</u> Examiner The law requires that the death certificate be executed burial-transi Acute Renal Failure 1 month and Due to (or as a consequence of): the attending physician by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificete 1 ☐ Yes 2 ☐ No 1 Yes 2 🔯 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 → No neral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred t Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death after death Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Loveen D59524 March 20, 2006 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Loveen J. Puthumana M.D. 3110 Gracefield Road; Silver Spring MD 20904 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State MAR 21 2006 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

			1 - For State Registrar	State of M	laryland /	-	artmen tificate			and M		Reg. No.UUb	10637
ı	Physici		1. Decedent's Name (First, Middle Evelyn P. Mea								2. Date of De Month March	ath 16,2006 Year	3. Time of Death 10:45 am M
	/Medic Examin		4a. Facility Name (If not institution, 5801 Springfie	give street and number	-)		Bet	hesc	Location o	of Death		4c. County of De	ery
	Funeral Director		5. Social Security Number 577-84-2276 Usual Residence of Decedent	6. Sex 7. A 1 ☐ M 2万 F	ge (In yrs. last b	irthday) Yrs.	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir Month, Da April	^y 1 ^y 2 ^{ar)} 1910Wes	ithplace (State or Foreign Country) L Virginia
	Maryland	tor	10a. State 10b. County MD Montgo	mery	10c. City, Tov Beth								10d. Inside City Limits 1 Yes 2 □ No
	with the	i Direc	10e. Street and Number 5801 Springfie	1d Dr.			10f. Zip	Code 0816				10g. Citizen of What C	Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "nature!", or Itams 23a or 28a-f show amportant: if item 27 is marked other than "nature!", or Itams 23a or 28a-f show amportant: it item 27 is marked other than "nature!" or Itams 12 in citilized at anote.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Deceden Armed Forces	2 1 No		Was Deced f Yes, spec		spanic Origin, Mexican	gin? (Spe i, Puerto f	cify Yes or No Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
Baltimore, Maryland 21215-0036	within 72 hou ane. Ihan "natura in Madical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education	75+)	(Give	dent's Usua kind of wor DO NOT us	k done d e retired)	uring mosi	t of workin	ng	16b. Kind of Busines Medical	
land 2	uld be filed v fental Hygie rkad othar t lic avant, II	To Be Co	17. Father's Name (First, Middle, I Calvin Parsons	<u> </u>		egr	50010	ı Nu.	18. Mothe		(First, Middle)	Maiden Sumame)	
Mary	nd 2 shou Ilth and M 27 is mai		19a. Informant's Name/Relations/ William Meade/S									er, City or Town, State, A,MD 20816	Zip Code)
more,	Pages 1 an ent of Heam nt: if itam		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		20b. Place cemete Park1	ery, c re r	natory`or o	ther place		-20-	ate 06	20c. Location - City o	
Balti	permit, Departm Importa any inju		21. Signature of Funeral Service I	igensee Bugger			Name an Jo. 5130	seph	Gaw1	er's	Sons, N.W. V	INC Vashington	DC 20016
	Pnysician	2	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on each	ed the death. Do line. rioscle:							rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	d	s a consequence		c oar	diov	ascas	Lur D	150450		
	ecuted and t-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence								
8760,	icate be executed physician and s the burial-transit	icai		d									
.O. Box 6	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2		Ectopic pr Other (sp					23d. Date of d Month	elivery Day Year
Ω.	ires tha signed d be de	by	Part II. Other significant conditio	ns contributing to death	but not resulting	in the u	nderlying c	ause give	in in Part I.			obacco use contribute Yes 2 XNo 3 ☐ F	to the cause of death? Probably 4 □Unknown
I Records,	The ate h page	Completed									24a. Was auto perfo 1 Yes		
Vital	Physician: The this certificate har director, page	To Be (25. Was case referred to medical examiner? 1X Yes 2 □ No	Hospital: 1 Inpa	tient 2□ER/C	Outpatier	nt 3 DC	A Othe			(Check only one	one) dence 6 □Other (Sp	ecify)
on of	ding Ph T. After th funeral		27. Manner of Death 1 X Natural 5 Pending 2 Accident investig			Time or Injury		8c. Injury Work	at	2		how injury occurred	
Division	a Hospital or Atten 24 hours after deatl Funaral Diractor: etely filled in by the	Certification:	3 Suicide 6 Could r 4 Homicide determi	ned 286. Place of I	njury - At home, etc. <i>(Specify)</i>	farm, str	reet, factory	, office		2	28f. Location (City or To	Street and Number or F wn, State)	Rural Route Number,
	To tha Hospital or Attent within 24 hours after deatl To tha Funaral Diractor: completely filled in by the	edical (g Physician: To the bes Examiner: On the basis and manners	of examination a								
)	To tha within 2 To tha complet	Ĕ	29b. Signature and title of certifier	- mc (0	mē)			. License				29d. Date signed (Mor March 20	,
	(O		30. Name and address of person Carl I. Margol	who completed cause of ${f ias}{f M.D.}11$	125 Roc	kvi1	le Pi	ke,	Rock	ville	,MD 20	851	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 1		strar's Signature	Mos	uli						

			1 - State of Maryland Registrar			of Heal			ene)	0638
	V () 3:	_ ^	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		ear (3. Time of Death
	Physici /Medic		WILLIAM T. MARTIN					MARCH 16			17:10 M
	Examin		4a. Facility Name (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL		4b. City, T	own, or Loca OLNEY	ation of Death		4c. County of		RY
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 2	t birthday) Yrs.	If Under 1 Months		Inder 24 Hrs. burs Min.	8. Date of Birth (Month, Day, June 18	^{Year)} 1913 V	Count	ace (State or Foreign (ry) Ington, D.C.
	the Maryland 28a-f ehow otified at	Director		Town or Lo	sprir			10	g. Citizen of Wh		0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with t	늅	460 Ednor Road		TOI. ZIP		905		United		1
036	be filed within 72 hours after death with the Maryland tall Hygiene. Id other than "natural", or itama 23e or 28e-f ehow event, I'm Medical Evarinar mast be rotified at	by Funeral	11. Marital Status 1 □ Never Married 2 ⋈ Marned 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ⋈ No If Yes, Give Year or Dates:	l I	Was Decede f Yes, specif	ent of Hispan fy Cuban, Mi		ecify Yes or No- Rican, etc.)	14. Race	America White, e	an Indian,
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vent, Ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 1.2 2	(Give life. L	dent's Usual kind of work DO NOT use ern Ma	retired)	g most of work		6b. Kind of Bus		1
and 2	ould be filed Mental Hygic erked other letic event, II	Be	17. Father's Name (First, Middle, Last) Thomas H. Martin				Mother's Name	e (First, Middle, M)	
Mary	id 2 should bith and Menti 27 is marked traumatice	T _o	19a. Informant's Name/Relationship (Type, Print) Elizabeth S. Martin / Wife					al Route Number, Spring		tate, <i>Zip</i> 20905	_
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		1 Burial 2 □ Cremation 3 □ Removal from State	etery, cren	sition (Name matory or oth eaven	ner place)	3/21		oc. Location - C		
Baltir	permit. F Departme Importer any injur		21. Signature of Funeral Service Licensee Murief H Barker	22				Funeral		- 13	20882
	Physician		23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition		er the mode		ch as cardiac o	Laytons or respiratory arre			Approximate Interval Between Onset and Death
8760,	Taw requires that the death certificate be executed as been signed by the attending physician and as been signed by the attending physician and 2 should be detached for use as the bunal-transit	dical Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence	nce of):							
P.O. Box 6	at the death certific by the attending p tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnant 1 Live birth 2 Fetal deceded 4 Pregnant at time of dear 9 Unknown	eath 3	Ectopic pre Other (spe				23d. Date Mont		ry Day Year
	puires that n signed b	by	Part II. Other significant conditions contributing to death but not resulti	ng in the u	nderlying ca	use given in	Part I.			ute to the	e cause of death? ably 4.20nknown
Records,	0 5 0	Completed						24a. Was an autopsy perform	ed? de	ere autop or to con ath?	osy findings available appletion of cause of
Vital		Be C	25. Was case referred to medical			26.	Place of Deat	h (Check only one			
of	ng Phys Iter this neral dir	ပ္		NOutpatien 8b. Time of Injury		Other: 4 Ic. Injury at Work? 1 Yes		me 5 Reside 28d. Describe ho)
Division	al or Attanding s after death. il Director: After d in by the fune	Certifications	3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	e, farm, str	reet, factory,	office		28f. Location (Str City or Town		or Rural	Route Number,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	ledical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowl and manner stated.								
	To the within	M	29b. Signature and title of certifier			License nur			d. Date signed		
•	15		Clerko farpuns			39793			Narch	17/2	1006
			30. Name and address of person who completed cause of death (Item 2) Chafstophus T. Mays, mb 1811	3a) (Type, Pemis	Print)	10 Do.	Olney	, my	16832		
	Sta Regist		30. Name and address of person who completed cause of death (Item 2 Chins County, MD 1810) 31. Date filed (Month, Day, Year) MAR 2 1 2005	9	we						

Physici /Medi Exami

Funeral Director

		For State Registrar		State	of Marylan		artment of F		Mental Hy	/giene Reg. No:	005	10639
Obvojaj		Decedent's Nam.							2. Date of Di Month	eath Day	Year	3. Time of Death
Physici Medic/		Judit		Ellen		luir			03	21	06	6.35 A.M.
Examin	er	4a. Facility Name (I	If not institutio	on, give street and i	number)		4b. City, Town, o	Location of Dea	ath	4c.	County of Death	
		5. Social Security N	a Mil	CART MC	SPITCU 7. Age (In yrs. I	last hirthday)	If Under 1 Year	If Under 24 Hr.	S. 8. Date of Bi	irth	HILE G.F.	place (State or Foreign
uneral irector		218-38-04		1□M ¾ □F			Months Days	Hours Mir		ay, Year)	Cou	intry)
		Usual Residence of							1101 07	, 1000	121	
ahow Data	_	10a. State	10b. County		10c. City	y, Town or Lo						10d. Inside City Limits
8a-f	Director	MD	Alleg	jany		Ва	rton					1 ∏Yes 2 ☐ No
B or 2		10e. Street and Nu		-1			10f. Zip Code			10g. Citiz	zen of What Cou	intry?
ne 23	Funeral	1891	ı/ Lat	robe Str	ect ecedent Ever in U.	S. 13.	2152 Was Decedent of H		Specify Yes or N		ed Stat	
	F	1 Never Marr	ied 2∏_Mai	Armed rried 1 ☐ Ye	Forces?		If Yes, specify Cuba	in, Mexican, Pue	erto Rican, etc.)		Black, White	, etc.
Exa	by	3 🗆 Widowed	4 □ Divorce	d If Yes.	Give r Dates:		1 □ Yes 2 XNo	Specify:			Specify: Wh	ite
natu Egg	etec	(Spec		nt's Education est grade complete	rd)	(Give	dent's Usual Occup kind of work done	durina most of w	orking	16b. Kir	nd of Business/la	ndustry
th a	Completed	Elementary/Seco	ondary (0-12)		g (1-4or 5+)		DO NOT use retired retary	1)		Medi	cal Fie	ld
nt,	0	17. Father's Name	(First, Middle,	Unknow	[]	DCC.	recary	18. Mother's Na	ame (First, Middle	e, Maiden i	Sumame)	
ked c ev	To B	Clarence	e Sude	er				Evelyr	n Broad	water		
e La		19a. Informant's N	ame/Relation	ship (Type, Print)		19b. Maili	ng Address (Street	and Number or F				p Code)
n 27 i		Michael M	Muir Sr	./Husban	d	1891	7 Latrobe	St, Bar	rton, Md	21521		
r of the		20a. Method of Dis		3 □Removal fro	m State	emetery, cre	sition (Name of matory or other place		Date	20c. Loc	cation - City or T	own, State
jury o		4 Donation	5 Other (Specify)	Lau		ill Cemet		4/06	Mosc	ow,Md	
Department of results and results by your "natural", or iteme 23s or 28s-f show any injury or other traumatic event, the Modical Examinar must be notified at once.		21. Signature of Fu	Ineral Service		Sal		2. Name and Addre Boal Fune Westernpo	ral Home		urch	St	
		23a. Part1. Enter t shock, or hea	the diseasé, c art failure. Lis	or complications that t only one cause of	n each line.	n. Do not en	ter the mode of dyin	ig, such as cardi	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
sician		Immediate Cause disease or condition resulting in death)	on	a	PAREUN	NONII	7					3 day.
ledical aminer		resulting in death)		Due	to (or as a consequ	uence of):						0
	er	Sequentially list co	onditions, nmediate	b	to (or as a consequ	uence of):						
ansit	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	erlying injury	1								
en en rial-tr	Exa	resulting in death)		Due	to (or as a consequ	uence of):						
physicien end s the burial-transit	dicai			d								
ding b	Med	IF FEMALE:		22a If use	autoom a of accord							
attend for us	by Physician/Me	23b. Was deceden in the past 12	months?	1 Liv	outcome of pregna e birth 2	Ideath 3	Ectopic pregnancy Other (specify)	,		2	3d. Date of deliving Month	<i>re</i> гу Day Year
y the	ysk	1 ∐ Yes 2√ 9 ☐ Unknown	No 1	9□ Un		5401 56	_ One (specify) _					
ned b deta	y Pt	Part II. Other signif	ficant condit	ions contributing to	death but not resi	-		en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
an síg uld bu	q pa	CERE	BROV	AS COULA	R Acc	1DEN			10	Yes 2	□No 3□Pro	bably 4 Unknown
2 sho	piet	RENA	L FAI	ASCOLA LURE					24a. Wa:	s an opsy	24b. Were aut	opsy findings available ompletion of cause of
ate ha page	Completed								perf 1 ☐ Yes	ormed?	death? 1 ☐ Yes	
ertific actor,	Be (25. Was case refer	rred to medica				1		eath (Check only			
this c al dire	2	1 □ Yes 200					nt 3 DOA Oth	4 Nursing	Home 5□ Res			rfy)
After	tion	27. Manner of Deat	5 ☐ Pendi	/8.4	te of Injury lonth, Day Year)	28b. Time o Injury	Wor	k? Yes 2 □ No	28d. Describe	now injury	y occurred	
ctor:	fica	½ ☐ Accident 3 ☐ Suicide	6 ☐ Could	Loot be	ace of Injury - At ho	ome, farm, st						al Route Number,
i Dire	Certification:	4 Homicide	deteri		ilding, etc. (Specify				City or To	wn, State)		
willing a rous area. Directors: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier (Check only one)		ing Physician: To I Examiner: On the and m								
To the	Me	29b. Signature and	title of certific				29c. Licens	e number		29d. Date	e signed (Month	, Day, Year)
		•	2	Fredm			126	907		MAT	RCH 21,	2006
0		30. Name and addi	ress of person			1 23а) (Туре,	Print)		l.			
X		DR. HARJIT	SIDHL		BISHOP W	ALSH R	D Cume	PERLAND	MD 21:	502		
Sta		31. Date filed (Mon	-		. Registrar's Signa	ture	1					
Registi	ar		WAR Z	2 2006	A STATE OF ARE A	Kills h	Corell 8					

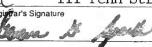
			FOI	epartment of Health and M Dertificate of Death		iene og. No. 006	10640
N.	+70	· · · · ·	Decedent's Name (First, Middle, Last)		2. Date of Deat Month	th Day Year	3. Time of Death
	Physici /Medic		Walter Norman Nei	tzey	March	17 2006	6:00 a ^M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			Futurecare Chesapeake	Arnold		Anne Arı	
1	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt Co	hplace (State or Foreign untry)
	Director		5/8-0/-3558	s.	Nov. 10	, 1915 Ner	w York
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Tow	or Location			10d. Inside City Limits
	Maryl f eho	٥	MD Queen Annes Steve	nsville			1 ☐ Yes 2√√No
	28e-	Director	10e. Street and Number	10f. Zip Code		0g. Citizen of What Co	
	3a or		148 Jean Road	21666		USA	,
	within 72 hours after death with the Maryland ene. Than "naturel", or Itame 23a or 28e-f ehow ha Madical Examinar must be notified at	Funeral		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
٥	or Ita		1 ☐ Never Married 2 ☐ Married │ 2002 Yes 2 ☐ No	vv	Rican, etc.)	Black, White	
212-0036	ral', c	l by	3 ∑Widowed 4 ☐ Divorced If Yes, Give Year or Dates: ₩₩II	1 ☐ Yes 2 1 ☐ No Specify:		Specify:	White
2	72 hc	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) (6	ecedent's Usual Occupation Give kind of work done during most of work	ina	16b. Kind of Business/	Industry
N	ithin 18.	ldu	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work fe. DO NOT use retired)		G(D m 1 1	
N	led w lygier her ti			staller	- /Fina 14:data	C&P Telepl	none
yiand	be fi	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam		vialuen Sumame)	
2	ould J Mer narke	T _o	Walter N. Neitzey			. O T O	
<u> </u>	12 st h and 7 ts n traun			Mailing Address <i>(Street and Number or Rur.</i> 48 Jean Road, Stever			Ip Code)
a, _	1 and Healt em 2 ther					20c. Location - City or	Town State
و	ages or or or		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery,	crematory or other place)			
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importanent of Health and Mental Hygiene. Instruction if the m27 is marked to ther than "natural; or trame 23a or 28e-f show eny injury or other traumatic event, the Medical Examinar must be notified at Once.		4 □Donation 5 □Other (Specify) Metro 21. Signature of Funeral Service Licensee	Crematory 3-2] 22. Name and Address of Facility	L-2006	Baltimore,	MD
ğ	permi Depa Impo eny ir		12 2. Cru	Hardesty Funeral	Home, P	.A.	1/01
			23a, Part1. Enter the disease, or complications that caused the death. Do no	12 Ridgely Avenue tenter the mode of dving, such as cardiac			Approximate
	用 元.		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	* -			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	ua			anys
	Examiner		Due to (or as a consequence of				U
		e.	Sequentially list conditions, b. — Due to (or as a consequence of)				
	uted ansit	ᇤ	Cause (Disease or injury				
-	be executed ician and burial-transit	Examiner	resulting in death) Last Due to (or as a consequence of)	:			
2/00	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical	d				
õ	certifica nding phy use as th	ed					
o D	h cer endir r use	Iclan/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of del	,
	death	SICIS	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)		Month	Day Year
5	at the by th	Physi	9 Unknown				
s,	requires that the een signed by th hould be detache	by	Part II Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		bacco use contribute to	. /
	equir en si ould	bel	Dementia	(5)	1 🗆 Ye	es 2□No 3□Pr	obably 4 Denknown
<u>က</u>	e law r has be je 2 sh	Completed	Cerebrovascular a	ccident	24a. Was a		topsy findings available completion of cause of
_	The ate h page	E O			perform	ned? death?	2 No
VIII	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	26. Place of Deat	h (Check only on	18)	
_	sic din	P.			ome 5 🗆 Reside	ence 6 Other (Spec	cify)
	ding Ph h. After th tuneral	:io	27. Mann Death 28a. Date of Injury (Month, Day Year) 1 7 atural 5 □ Pending (Month, Day Year)	ary Work?	28d. Describe ho	ow injury occurred	
VISION	tendi eath. tor: A the fu	catl	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
<u> </u>	or At fter d Sirect in by	ertification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (St City or Town	treet and Number or Ru n, State)	iral Route Number,
	pital urs a sral (O	Con Continue and Continue Discourse To the Continue To the Con				
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	dical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check only one) 1 Medical Examiner: On the basis of examination and/one) and manner stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	ithin o the	Med	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Monti	n. Day, Year)
	F 3 F 8			11 750725	i ·	8-17-0	2006
			3 me and address of person who completed cause of death (Item 23a) (T	voa Print)	,		
			cknniter Riodinear Stati Vot	eransting Mil	lersul	la MI	21108
100	Sta	ite	31. Date filed (Month, Day, Year) 37 Registrar's Signature		J. 37.C		2/100
	Registr		MAR 2 1 2006 1000 15 1	books			

Aaron Scott	Nesspor
-------------	---------

			-
	Certificate of Death Reg. No.		
	Contitions of Double to UUU I	0091	ĺ
)L	State of Maryland / Department of Health and Mental Hygiene 06	0641	Married Land
220			

			1 - State Registrar	,	Cei	tificate of	Death		Reg. N	UU0	10041				
	Physic		Decedent's Name (First, Middle, La AARON SCOTT N	· ·			127	2. Date of D Month March			3. Time of Death 23:42 P M				
	/Medi Examii		4a. Facility Name (If not institution, given 23315 Old Chester						4	c. County of Death					
	Funeral Director		5. Social Security Number 6. 5		yrs. last birthday) 1 Yrs.	If Under 1 Year Months Days		Kent 9. Birthplace (State or Foreign Country) MD							
	ryland how		Usuel Residence of Decedent 10a. State 10b. County		. City, Town or Lo						10d. Inside City Limits				
	8a-1 s	Director	MD KENT		ROCK HAL						1 X Yes 2 □ No				
	ath with the 23a or 2	ral Dire	10e. Street and Number 5836 HAVEN COURT			10f. Zip Code 21661		_	itizen of What Cou USA	intry?					
Baltimore, Maryland 21215-0036	within 72 hours atter death with the Maryland sne. than "natural; or itema 23a or 28a-f show ha Madical Examinar mark to molified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 □Yes 2 ☑No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 Yes 2 No Specify:			0-	14. Race - Ameri Black, White, Specify: WHI	, etc.				
	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or 5+)	(Give		edent's Usual Occupation e kind of work done during most of worki DO NOT use retired) FERMAN			Kind of Business/Ir	ndustry				
	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Madical Examinant remailise notified at one.	To Be C	17. Father's Name (First, Middle, Last BRIAN SCOTT NES				18. Mother's Nam LAURA LE			n Sumame)					
			19a. Informant's Name/Relationship (BRIAN NESSPOR/FA	*			ST., ROC		-		o Code)				
			20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State CI	b. Place of Dispo cemetery, cren HESTER C	natory or other pla	ce)	Date 4/2006		ocation - City or T					
Balt			21. Signature Funeral Service Lice	ellords	22 F1 1.	Name and Addre ELLOWS, I 30 SPEER	ess of Facility HELFENBEL ROAD, CH	N & NEW ESTERTO	NAM WN,	FUNERAL MD 21620	HOME, P.A.				
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the cone cause on each line. a. Due to (or as a con	EMURG	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death				
68760,	ficate be executed physicien and strength transit	ysician/Medical Examiner	Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con										
.O. Box 687	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached tor use as the burial-transit					Physician/Media	-	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	_d. 23c. If yes, outcome of pre 1	etal death 3	Ectopic pregnancy Other (specify) _	1		
Δ.	w requires that been signed b should be deta	ρ	Part II. Other significant conditions (contributing to death but not	resulting in the un	derlying cause giv	ren in Part I.	23e. Did 1		use contribute to the	he cause of death?				
Vital Records,		Completed						24a. Was auto perio		prior to co	psy findings available mpletion of cause of				
	Physiclan: this certitional director,	o Be	25. Was case referred to medicat examiner? 1√∑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatient	3□ DOA Oth	26. Place of Deat								
ion of	a fe	-	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time of	28c. Injur Wor	y at k?	ng Home 5 ☐ Residence 6 ▼Other (Specify) Scene 28d. Describe how injury occurred							
Division	tal or Attendi rs after death. al Director; A ed in by the tu	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injury - A building, etc. (Spi	At home, farm, streecify)	, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number Or Town, State)									
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	edical	29a. Certifier (Check only one) 1 ☐ Certifying Ph	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	occurred at the tin estigation, in my o	ne, date and place, pinion, death occur	and due to the	cause(s	and manner as s	tated				
)	To the transfer of the transfe	M	29b. Signature and title of certifier	Shoe i	mo	29c. Licens		1		te signed <i>(Month,</i> h 18, 200	,				
8)	Ms		30. Name and address of person who MDNGDNHD A	completed cause of death (et, Baltin	nore, Ma	ary1	and 21201	l				

State Registrar



			For State Registrar	State	of Marylar		artment of F				ene 0 0 6	10642		
			1. Decedent's Name (First, Middle, I	_ast)					2	2. Date of Death Month	Day Ye	3. Time of Death		
	Physici /Medic	al	Lawrence Walter								16, 2000	3 2:10 P M		
	Examin	er	4a. Facility Name (If not institution, g				4b. Cily, Town, o			-	4c. County of Death Calvert County			
	Cuperal		Calvert Memoria 5. Social Security Number 6	1 HOSPIT	7. Age (In yrs.	last birthday)	Prince	If Under		B. Date of Birth (Month, Day, 1		Birthplace (State or Foreign Country)		
	Funeral Director	- 1	577-56-6355	1 ₹ M 2 □ F	65	Yrs.	Months Days	Hours	Min.	Month, Day, 1 Feb。20	1941 V	Vashington, DC		
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	ecation				10d. Inside City Limits			
	Aaryla shor	ō		C .			oation					1 ☐ Yes 2 No		
	the N	Director	MD Calvert 10e. Street and Number	County	Liu	ısby	10f. Zip Code		-	10	g. Citizen of What	t Country?		
	h with	ai Di	334 Sachem Dr	ive			20657	7			U.S.A.	•		
	ems 2	Funerai	11. Marital Status	12. Was Dec	edent Ever in Lorces?	J.S. 13.	Was Decedent of H	lispanic Ori an, Mexicar	gin? (Spec	ify Yes or No- ican, etc.)		American Indian, Vhite, etc.		
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, G	2∭XNo ive		1 ☐ Yes 2 🗓 No			,	Specify: V			
215-0036	filed within 72 hours after death with the Maryland Hygiene. ythar then "natural", or items 23a or 28a-f show ant, it e Madical Examinar must be mailfied at	ed b	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's	Year or I	Dates:	16a, Dece	dent's Usual Occup	ation		11	6b. Kind of Busine	ess/Industry		
715	nin 72 nin Madis	piet	(Specify only highest : Elementary/Secondary (0-12)	grade completed, College ((Give	kind of work done DO NOT use retire	during mos	t of working	9		,,		
7	d with	Completed	8	College	1-401 017	Ti	le Setter	r			Tile Co	ompany		
pu	be file tal Hy d oth avant	Be	17. Father's Name (First, Middle, La	st)						(First, Middle, M.	aiden Sumame)			
Maryland	d Men d Men narke	2	Earl Nalls 19a. Informant's Name/Relationship	(Type Print)		10h Mailie	ng Address (Street	L	rothy		City or Town Stat	to Zin Codo)		
a Z	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked othar than "naturat", or items 23a or 28a-f show any injury or other traumatic avant, if we Medical Examination in at be millined at once.				-1-4							laryland 21146		
	s 1 an f Heal itam 2 other		Elizabeth J. Nal 20a. Method of Disposition	•	20b.	Place of Dispo	sition (Name of natory or other place		Da	ite 2	Oc. Location - City			
Baltimore,	Page nent o nt: If ry or		1 ☐ Burial 2 XCremation 3 1 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from city)	State	e Crem	-) I	March 200		Clinton	Maryland		
alti	permit. Departm Importa any inju		21. Signature of Fundamental	этсее		22	2. Name and Addre	ss of Facilit	^{ty} Lee I	Funeral	Home Cal	vert, P.A.		
<u> </u>	82589		Michael W.	ee		8	<u> 125 South</u>	nern M	Maryla	and Blvc	l., Owing	gs. MD 20736		
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that ly one cause on	caused the dea each line.							Approximate Interval Between Onset and Death		
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Acu	te on	dro	nic hyp	ercopy	are 1	respirat	ory fails	re days		
þ	Examiner			· ·	(or as a consec	quence of):	- N	i di		1	i Ingga	years		
		er	if any, leading to immediate cause. Enter Underlying		(or as a consec	quence of):	112 055	prock,	ve pu	mona) discore	gears		
	cuted Id ransit	Examiner	that initiated events											
Ö,	ate be executed hysician and the burial-transit	i Ex	resulting in death) Last	Due to	(or as a consec	quence of):								
8760,	icate b physic s the b	dicai		d										
9 X	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, ou	itcome of pregn	ancy					23d. Date of	delivery		
Вох	death atter	iciar	23b. Was decedent pregnant in the past 12 months?		birth 2 Feta nant at time of the		Ectopic pregnancy Other (specify)	у			Month	Day Year		
P.0.	that the de led by the a detached t	hys	9 Unknown	9□ Unkı	nown									
	res tha igned be del	by P	Part II. Other significant condition	_		-						e to the cause of death?		
ord	w require been si should I	ted	Insulin-repurs	ry dial	retes ne	illit va	, type	<u></u>		1 Ves	2 □ No 3 □	Probably 4 Unknown		
Records,	e faw r has be je 2 sh	Completed		<u>-</u>						24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of		
al	r. The									1 ☐ Yes 2	9 % 6 10			
Vital	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	25	7.50/0-4	Ott	200		(Check only one		2		
of			27. Mann of Death		Inpatient 2 L of Injury oth, Day Year)	ER/Outpatier 28b. Time o				d. Describe hov	ice 6 Other (5 v injury occurred	specify)		
ion	uttanding death. ctor: Afte y the fune	atio	1		ntn, Day Year)	Injury		rk? Yes 2. □	No					
Division	r Atta er de; recto by th	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flau	e of Injury - At h	nome, farm, str ify)	eet, factory, office		28	3f. Location (Streetly or Town,		r Rural Route Number,		
	ital or A irs after ral Directled in by										·			
	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Ex	aminer: On the	pasis of examin		h occurred at the til vestigation, in my o					r as stated. due to the cause(s)		
	o tha ithin 2 o tha omple	Med	one) 29b. Signature and title of certifier	and ma	nner stated.		29c. Licens	se number		290	d. Date signed (M	onth, Day, Year)		
	To To		M. mo				060	390			3/17/	2006		
	-		30. Name and address of person when the same address of person when th	no completed cau	se of death (Ite	т 23а) (Туре,	Print)							
	5		ADEEB JAB		00 Ho	SPITAL	RO.	Pair	UCE F	FREDER	ICK, MJ	0 20678		
	Sta		31. Date filed (Month, Day, Year)	2 1 2nns	Registra s Sign	ature	Sparte	P			,			
	Registi	ar	MMIN	~ I C000	- PERSON	5.1 JU	Paraner	VS.						

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760, PAUL EDWARD NESTOR

	1 - State Registrar			Ce	rtificate	or Dea	tti i	2. Date of I	Reg. I	No.		2 Time (D
in	1. Decedent's Name (First, Middle		.0.25							^{Day} 2006	Year	3. Time of Dea
al	Paul Edwar 4a. Facility Name (If not institution				4b. City, To	own, or Local	tion of Death			4c. County o		
er	St. Mary's Ho				Leona				į	st.	Maı	ry's
-	5. Social Security Number	6. Sex 1 M 2 □ F	7. Age (In y	rs. last birthday	/) If Under 1 Months I	Year If Ur Days Hou	nder 24 Hrs. urs Min.	8. Date of E (Month, I	Birth Day, Yea	ar)	Cou	place (State or Fo
	157-14-7550 Usual Residence of Decedent	M 2UF	80	Yrs.				Oct	21	1925	Nev	w Jerse
	10a. State 10b. County		10c.	City, Town or L	ocation							10d. Inside City Li
to	Maryland St. Mary's Charlotte Hall										1 □ Yes 2 √	
i Direc	10e. Street and Number 29449 Charlo	otte Hal	ll Roa	ad	10f. Zip C					Citizen of Wi		
by Funeral Director	11. Marital Status ** Never Married 2 Marr	Armed F		n U.S. 13.	. Was Deceder	y Cuban, Me	xican, Puerto	pecify Yes or I o Rican, etc.)	No-	Black	, White,	can Indian, , etc.
	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 43-45									Specify:	WII.	
Completed	15. Decedent (Specify only highes	st grade completed		(Giv	edent's Usual (e kind of work DO NOT use	done durina	most of work	king	160	. Kind of Bus	siness/ir	ndustry
E O	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)	Disa	bled V	/eter	an		Mi	litar	cy I	Navy
Bec	17. Father's Name (First, Middle,							ne (First, Midd		den Surname	9)	
일	William Chr		r Nest					Oliv			=	
1 1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hollowell – executor General Delivery Fort Republic MD 20676											
	20a. Method of Disposition	300		b. Place of Disc	osition (Name	of	1	Date		. Location - C		own, State
	1 ☑Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			cemetery, cre uanitco	ematory or oth Nation	_			Tri	iangle	Viı	rginia
	21. Sign thus of Fuseral Service		, Ot		22. Name and		acility			and Ho		
П	1019au	och		4	405 Bro	omes		usch F				20676
	23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.	leath. Do not er	nter the mode	of dying, suc	ch as cardiac	or respiratory	arrest,			Approximate Interval Between
	Immediate Cause (Final disease or condition Hypoxic or spi outer, fail 162											Onset and Dea
	resulting in death) Due to (or as a consequence of):										11071	
	,	Due to	o (or as a cons	sequence of):		C- +	- 1					
_	Sequentially list conditions.	b. Due to	Shoc	sequence of):	Mulh	fa ct	vial					Hours
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	o (or as a cons	seguence of).						e 4 & Z	-	
xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	С <u>С </u> У	Shoci o (or as a cons o (or as a cons ovni c o (or as a cons	seguence of).						e u fz Ibahi	-	Hours
cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	С <u>С </u> У	o (or as a cons	seguence of).	Mulh trucs					e u fz 16ah	- -	Hours
edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С <u>С </u> У	o (or as a cons	seguence of).						16 abo	-	Hours
edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	c. C y Due to	o (or as a cons	sequence of): C 4 5 sequence of):	tmc9	ve p				23d. Date	of deliv	Hours Hours
edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	c	o (or as a cons	sequence of): C 6 5 sequence of): ognancy etal death 3		ye p					of deliv	Hours Hours
edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Cy Due to d. 23c. If yes, o 1 Live 4 Pred 9 Unk	o (or as a constitution of or	sequence of): C 6 5 sequence of): agnancy estal death 3 of death 5	Ectopic prec	gnancy	ey me	FX	ch's	23d. Date Mon	e of deliv	Hours Hours Yery Day Yea
by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	c. Cy Due to d. 23c. If yes, o 1 Live 4 Pred 9 Unk	o (or as a constitution of or	sequence of): C 6 5 sequence of): agnancy estal death 3 of death 5	Ectopic prec	gnancy	ey me	23e. Di	ch's	23d. Date Mon	e of deliv	Hours Hours Tours Year The cause of death
by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. C y Due to d. 23c. If yes, o 1 Live 4 Pred 9 Unk	o (or as a constitution of or	sequence of): C 6 5 sequence of): agnancy estal death 3 of death 5	Ectopic prec	gnancy	ey me	23e. Di	CH S	23d. Date Moni co use contril 2 \(\square\) No	e of delivith	Hours Hours Yery Day Year the cause of death bably 4 □Unkr
by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. C y Due to d. 23c. If yes, o 1 Live 4 Pred 9 Unk	o (or as a constitution of or	sequence of): C 6 5 sequence of): agnancy estal death 3 of death 5	Ectopic prec	gnancy	ey me	23e. Di	d tobacc	23d. Date Moni co use contril 2 \(\sum \) No 24b. W pr	e of delivith bute to 3 Pro Vere authrior to coeath?	Houss Houss Thouss Thous
Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Cy Due to d. 23c. If yes, o 1 Live 4 Pred 9 Unk ons contributing to	o (or as a constitution of or	sequence of): C 6 5 sequence of): agnancy estal death 3 of death 5	Ectopic prec	gnancy cify) use given in F	ed mel	23e. Di	d tobacc	23d. Date Moni co use contril 2 \(\sum \) No 24b. W pr	e of delivith bute to 3 Pro Vere authrior to coeath?	Hours Hours Tours Tery Day Year the cause of death bably 4 □Unkr opsy findings ava
o Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Cy Due to d. 23c. If yes, o 1 Live 4 Preg 9 Unk ons contributing to	utcome of pre- birth 2 F gnant at time of nown	sequence of): C 6 5 sequence of): agnancy estal death 3 of death 5	Ectopic pre	gnancy cify) use given in F	Place of Dea	23e. Di	d tobacco	23d. Date Moni	bute to Greath? Yes	Hours Hours Thours
To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to C. Due to	o (or as a constitution of or	sequence of): c 6 5 sequence of): sequence of):	Ectopic pred Other (spector) underlying cau	gnancy gn	Place of Dea	23e. Di	d tobacco	23d. Date Moni	bute to Greath? Yes	Hours Hours Tours Tours Thours Th
To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to C. C y Due to d	utcome of prebirth 2 Finant at time of nown	sequence of): c 6 5 sequence of): sequence of):	Ectopic pred Other (spector) underlying cau	gnancy grify) use given in F	Part I. Place of Dea	23e. Di	d tobacco	23d. Date Moni	bute to Greath? Yes	Hours Hours Thours
To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to C. Une to Due	o (or as a consultation of present a consult	egnancy etal death 3 of death 5 resulting in the 2 ER/Outpatie r) 28b. Time Injury	Dectopic prediction of 286	gnancy gnancy gnancy gnancy gnancy gnancy 26.1 Other: 4 C. Injury at Work? 1 □ Yes	Part I. Place of Dea	23e. Di 24a. W au pe 1 Yes th Check onlone 5 Re 28d. Describ	d tobacc Yes as an topsy rformed (s 2) (one) esidence we how in	23d. Date Moni	bute to Great authorized to the control of the con	Hours Hours Thours Thours The cause of death The bably 4 Dukr The cause of death
Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to C. Due to Due	utcome of prebirth 2 Finpatient 2 e of Injury and ing. etc. (Sp.	sequence of): C 6 5 sequence of): sequence of):	Ectopic precipitation of the control	gnancy ify) 26. I Other: 4 C. Injury at Work? 1 □ Yes office	Part I. Place of Dea	23e. Di 24a. W au pe 1 Yes th Check onlone 5 Re 28d. Describ	d tobacco Yes as an topsy rformed 2 y one) asidence te how in	23d. Date Monitor of the Monitor of	bute to a of delivith bute to a province author to coeath? Yes ar (Special	Hours Hours Thours Thours The cause of death The cause of dea
Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to C. Un Due to d. 23c. If yes, o 1 Live 4 Pre- 9 Unk ons contributing to 28a. Date (Mo gation not be not be 28e. Plate nined 28e. Plate puil Examiner: On the	utcome of prebirth 2 Finantient 2 e of Injury onth, Day Year ding, etc. (Sp.	sequence of): C 6 5 sequence of): ggnancy fetal death 3 of death 5 resulting in the 2 C ER/Outpatie () 28b. Time Injury At home, farm, secity)	Ectopic prediction of the control of	gnancy sifty) 26. I Other: 4 (c. Injury at Work? 1 □ Yes office	Part I. Place of Dea Nursing H 2 \[\] No	23e. Di	d tobacce Yes as an topsy rformed yone) asidence how in (Street Town, Si	23d. Date Monico use contril 2 \(\text{No} \) No 1 \(\text{No} \) 1 \(\text{No} \	bute to a Pro Vere autrior to coeath? Yes or (Special	Hours Hours Thours Thours The cause of death The cause of dea
To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to C. Un Due to d. 23c. If yes, o 1 Live 4 Pre- 9 Unk ons contributing to 28a. Date (Mo gation not be not be 28e. Plate nined 28e. Plate puil Examiner: On the	o (or as a consultation) of (or as a consult	sequence of): C 6 5 sequence of): ggnancy fetal death 3 of death 5 resulting in the 2 C ER/Outpatie () 28b. Time Injury At home, farm, secity)	Ectopic prediction of the control of	gnancy sifty) 26. I Other: 4 (c. Injury at Work? 1 □ Yes office	Part I. Place of Dea Nursing H 2 No	23e. Di	d tobacc Yes as an topsy normed soldence e how in (Street Fown, Si	23d. Date Monitor See Control 2 No 3 No 1	bute to 3 Pro Vere autrior to ceath? Yes or (Special	Hours Hours Thours Thours The cause of death Thouse The cause of death Thouse The cause of death Thouse The cause of death Thours
Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to C. Un Due to d. 23c. If yes, o 1 Live 4 Pre- 9 Unk ons contributing to 28a. Date (Mo gation not be not be 28e. Plate nined 28e. Plate puil Examiner: On the	utcome of prebirth 2 Finantient 2 e of Injury onth, Day Year ding, etc. (Sp.	sequence of): C 6 5 sequence of): ggnancy fetal death 3 of death 5 resulting in the 2 C ER/Outpatie () 28b. Time Injury At home, farm, secity)	Ectopic prediction of the control of	gnancy sify) 26. I Other: 4 Work? 1 □ Yes office	Part I. Place of Dea Nursing H 2 No	23e. Di	d tobacc Yes as an topsy normed soldence e how in (Street Fown, Si	23d. Date Moni 2 ouse contril 2 ouse contril 2 No 3 24b. W pr 3 de Othe 3 6 other 3 njury occurre 4 and Number 4 and Number 4 and place, and	bute to 3 Pro Vere autrior to ceath? Yes or (Special	Hours Thours
Certification; To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to C. Un Due to d. 23c. If yes, o 1 Live 4 Pre- 9 Unk ons contributing to 28a. Date (Mo gation not be not be 28e. Plate nined 28e. Plate puil Examiner: On the	utcome of prebirth 2 Finantient 2 e of Injury onth, Day Year ding, etc. (Sp.	egnancy egnancy etal death 3 of death 5 resulting in the 2 = ER/Outpatie r) = 28b. Time Injury At home, farm, s ecify)	Ectopic prediction of 28 mg. M. Street, factory, ath occurred at investigation, in 29c.	gnancy gn	Part I. Place of Dea Nursing H 2 No	23e. Di 24a. W au au 1 Yes th (Check onl 28d. Describ 28f. Location City or i	d tobacc Yes as an topsy normed soldence e how in (Street Fown, Si	23d. Date Moni 2 ouse contril 2 ouse contril 2 No 3 24b. W pr 3 de Othe 3 6 other 3 njury occurre 4 and Number 4 and Number 4 and place, and	bute to 3 Pro Vere autrior to ceath? Yes or (Special	Hours Hours Thours

10+

			For State Registrar	State of Ma	ryland		rtment of H		nd Mental F	lygien	2000	10644	
+	Physici /Medic		1. Decedent's Name (First, Middle, Las	AK					2. Date of Month	H 1	18 200	3. Time of Death	
4	Examir Funeral Director	er	4a. Facility Name (If not institution, give SHAOU CROVE 5. Social Security Number 215 78 1780 Usual Residence of Decedent	JENTIST	HOSP (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of	Birth Day, Year	c. County of Death 00760 M 9. Birth 1,1933	0	
	Maryland -f ehow	tor	10a. Stale 10b. County MD MONTGO	MERY		Town or Lo	cation RSBURG					10d. Inside City Limits 1XXes 2 □ No	
	th the	lirec	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cou	intry?	
	ath w	rai	17060 KING JAM				2087				S.A		
036	72 hours after death with the Maryland hatural; or iteme 23a or 28e-f ehow digal Expirator meat by indified at	by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:		If	Vas Decedeni of I Yes, sp <i>e</i> cify Cub	lispanic Orig an, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: AS	, etc.	
21215-0036	within ane. than	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 2		-)	(Give life. L	ent's Usual Occup kind of work done OO NOT use retire	oation during most d)	of working		Kind of Business/li	·	
	filed Hygie Sther		17. Father's Name (First, Middle, Last)			MECI	IANIC	18. Mother	's Name (First, Mid	_			
/lan	iould be I Mental narked c	To Be	SI HANG PAK					YU	PAK				
, Maryland	1 and 2 should be Health and Mental tem 27 is marked of		19a. Informant's Name/Relationship (7 YUNG SON PAK		ON	170	060 KIN					rp Code) RSBURG MD	
Baltimore,	Page ento nt: If ry or		20a. Method of Disposition Description 3 De	(cer	netery, cren BECK	sition (Name of natory or other pla MEMORI	AT.	Date 3/22/06		Location - City or T		
Balt	permit. Departm Importe any inju		21. Signature of Funeral hery ce Licen	, see		22	Name and Address	ss of Facility	CHARLES UPPE			RAL SERV MD 20772	
8760,	Physician and // Medical Examiner the pnrian-transit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a d. Due to (or a) d. Du	e. PS conseque	Sence of):	or the mode of dys	ng, such as c	ardiac or respirator	y arrest,		Approximate Interval Between Onset and Death	
.O. Box 68	death certif e attending id for use a:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the pasl 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnanl at 9 □ Unknown	2 ☐ Fetal d	death 3	Ectopic pregnand Other (specify)	у			23d. Date of deliving Month	very Day Year	
<u>α</u>	w requires that the been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death bu	t not result	ting in the ur	nderlying cause gr	ven in Part I.				the cause of death?	
of Vital Records,	The la ate has page 2	Completed			-				24a. W au pv 1 □ Ye	itopsy intormed?	prior to co	opsy findings available ompletion of cause of	
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			. 04	or	of Death (Check on				
	ding Phys h. After this funeral dir	ıtlon: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day		R/Outpatien 28b. Time of Injury	28c. Inju				6 ☐Other (Specury occurred	ify)	
Division	al or Attends safter death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Location ((Street and Number or Rural Route Number, own, State)		
	To the Hospital or Al within 24 hours after or To the Funeral Direct completely filled in by	edical C		ysician: To the best of iner: On the basis of and manner sta	examination								
	To the within 2. To the complet	ž	29b. Signature and little of certifier	\ .			29c. Licen:				ate signed (Month		
)	(3)		1 Called	Here	MO		59	249		MA	RC4 19,	2006	
R	(3)		30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type,	Print)	- 12/1 -	e Rocki	.11.	ma a	265	
10	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2 2 2096		r's Signatu	See			- NOCEO	HE,	(1'11) 2		

			1 - For State Registrar	State of Maryland / [Departm <i>Certific</i>				giene Reg. No.	006	10645
3	驰	-	Decedent's Name (First, Middle, Last	it)				2. Date of De.	ath		3. Time of Death
15	Physici		Pornard Do	rrt				Month	16.	Year 2006	10:02A M
	/Medic		Bernard Pe	rry street and number)	4b. C	ity. Town, or	Location of Dea			County of Death	
	Examin								Dr	ince G	lanrae
	Funcial		Southern Maryla 5. Social Security Number 6. S	nd HOSPITAL ex 7. Age (In yrs. last bir	thday) If Ur	linto	If Under 24 Hrs		h 195		
	Funeral Director	7.		M	Yrs. Mon	hs Days	Hours Min	Augus		Jact	place (State or Foreign intry) SON
A).	A 1		Usual Residence of Decedent					11300,00			Tennessee
	ylanc		10a. State 10b. County	10c. City, Tow	n or Location						10d, Inside City Limits
	Mar.	tor	Maryland Prince	George Clint	on						1∭Yes 2☐No
	1 the	rec	10e. Street and Number	Occi ge	10f	Zip Code			10g. Citiz	en of What Cou	intry?
	3a o	0	8600 Pretoria	Court	2	0735		T	Init	ed Sta	tes
	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinatments is indiffied at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S.			spanic Origin? (Specify Yes or No rto Rican, etc.)		4. Race - Amer	ican Indian,
10	fler of the control o	Ē	1 Never Married 2 Married	Armed Forces? 1 XYes 2 □ No				no Hican, etc.)		Black, White	
93	urs a	by	3 ☐ Widowed 4 MiDivorced	If Yes, Give Year or Dates: Army	1 L Ye	s 2XX No	Specify:			Specify: B1	ack
21215-0036	2 ho	Completed	15. Decedent's Ed	ucation 16a	. Decedent's	Jsual Occupa	tion	attin a	16b. Kir	nd of Business/I	ndustry
215	7 nin 7 n n	pie	(Specify only highest gra	College (1-4or 5+)	life. DO NO	T use retired)	uring most of wo	orking	Prin	nce Ge	orge .
212	r tha	E	12		Admin	istrat	tor		Depa	artmen	orge prrections
	Hygie other	0	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden :	Sumame)	
an	d be ental kad	To B	Lenoard Perry				Berni	ce Woma	ck		
Maryland	2 should be filed withir and Mental Hygiene. ie markad other than aumatic event, the Ms	Ι-,	19a. Informant's Name/Relationship (Type, Print) 19t	. Mailing Add	ress (Street a	nd Number or R	Tural Route Number	er, City or	Town, State, Z	ip Code)
∑ S	d 2 in ar in		Kevin Perry/ So	on 9	31 Sa	int M	i chael	s Drive	Mai	yland chell	
Ġ,	1 and 1 Health tem 27		20a. Method of Disposition	20b. Place o	f Disposition	Name of		Date		cation - City or 1	
Baltimore,	Pages nent of I int: if its iry or o		1 X Buriaf 2 Cremation 3		chape	or other place 1 CME	200		-		-
ij			4 Donation 5 Other (Specif	Churc	h Cem	eterv	Mar	ch 25,			Tennessee
3al	permit. Departrimports imports eny inju		21. Signature of Funeral Service Licer	1/2				urray F			
1000	20 = 0 d		Frump 13	11/02				NW Wash		ton, D	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caused the death. Do one cause on each line.	not enter the	mode of dying	, such as cardia	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	CAROIN	ARWA	Thu	mo-				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence	of):	1					· · · · · · · · · · · · · · · · · · ·
	Examiner		Commentally list and delicar	· Conoma	1. *	Inter	un Di	22022	2		
λ		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	of):		- 3				
	d d ansit	E	Cause (Disease or injury that initiated events	· HURAT	ens.	60					
Ć,	exectin an ial-tr	Examiner	resulting in death) Last	Due to (or as a consequence	of):						
8760,	icate be executed physician and the burial-transit	dical	(d							
68	ificat g phy as th	edi									
Вох	requires that the death certific teen signed by the attending pl hould be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome of pregnancy	• 🗆 = .				2	23d. Date of deli	very
B	atte atte	cia	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetaf death 4 ☐ Pregnant at time of death	n 3∐Ectop 5∏ Othe	ic pregnancy r <i>(specify)</i>				Month	Day Year
0	y the	ıysi	9 Unknown	9□ Unknown							
α.	res that the de igned by the a be detached f		Part If. Other significant conditions of	ontributing to death but not resulting	in the underlyi	ng cause give	n in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
Records,	sign d be	d by						10	Yes 2	No 3∏ Pro	bably 4 Unknown
Ö		ete						24- 146-		0.45 144	and the second section
lec	s law has b e 2 sl	Idu				.,		24a. Was		prior to c	topsy findings available ompletion of cause of
H	sician: The law certificate has b irector, page 2 s	Completed						1 ☐ Yes	2 X) No	death? 1 ☐ Yes	2 No
of Vital	iding Physician: th. After this certifica funeral director, p	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Check only o	one)		
f V	nysic nis ce dire	2	1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	utpatient 3	DOA Othe	or: 4 Nursing	Home 5 ☐ Resi	dence 6	Other (Spec	rify)
0	ig Pl		27. Manner of Death 1 X Natural 5 ☐ Pending		Time of Injury	28c. Injury Work	at	28d. Describe	how injury	y occurred	
Division	Attending r death. ector: After by the fune	atic	2 ☐ Accident investigatio		М		res 2 □ No				
<u>×is</u>	Atte	ific	3 Suicide 6 Could not b	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, fa	ctory, office		28f. Location (City or To			ral Route Number,
Ö	al or s afte ii Dir	Certification:	4 LI HOMICIAE	Building, etc. (Specify)				only or vo	, 5.0.0)		
	spit noun			ysician: To the best of my knowledg							
	P HC	Medical	(Check only 2 Medical Examone)	niner: On the basis of examination as and manner stated.	nd/or investiga	ition, in my op	oinion, death occ	curred at the time,	date and	place, and due	to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	₩.	29b. Signature and title of certifier			29c. License	number		29d. Date	e signed (Monti	n, Day, Year)
				K-		n 001	1 5 0 0		10 20	h 17,	2006
	10		30. Name and address of person who	completed cause of death (Item 22a)	(Type Price)	D 004	1580	[1al C	t.1 1/	2000
	631					a	4 4 -	Ma a	7	20725	
le.	() () () () () () ()	100	Dr. Scott Kels 31. Date filed (Month, Day, Year)	7503 Surratt 32. Registrar's Signature	s Koa	a CI	inton,	maryla	no	20/35	
	Sta Regist		MAR 2 1 2006	der di braile							

			i lease i	Ctate of Manier				-		1 25 m 1 et
			for State	State of Marylar					6.000	10646
			Registrar		Ce	rtificate of L	Jean	2. Date of Dea	Reg. No.	2 Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)					Month	Day Year	3. Time of Death
	/Medic		Dorothy	Phoebus				13/	20/00	*
•	Examin	er	4a. Fecility Name (If not institution, give	- (1 -		4b. City, Town, or		tn	4c. County of De	~
	<u></u>			105 Time Syric	al histogram	If Under 1 Year	U-Under 24 Hrs	R Date of Birt	Wicem	
	Funeral		10	M 2DF 87		Months Days	Hours Min		Year)	rthplace (State or Foreign Country)
×.	Director		220-18-0431 Usual Residence of Decedent					1 9/1	2/11/11	10
	/land		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Man First	ţ	Maryland Wicom:	ico S	alisbur	.y				1X Yes 2 No
	r 28s	lrec	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
	ilied within 72 hours after death with the Maryland Hygiene. other than "naturel", or liems 23s or 28s-f show ent, tha Madical Examinar must be notified at	Funeral Director	105 Times Square			2180	01		USA	
	dea ems	ner	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - An Black, Wh	
9	or It.	Fu /	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes 💥 ☐ No		, , , , , , , , , , , , , , , , , , , ,	Specify:	white
8	urel',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						
<u>V</u>	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ie completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	orking	16b. Kind of Busines	s/industry
7	withir	m	Elementary/Secondary (0-12)	Sollege (1-4or 5+)	Nur		,		Health	are
2	Hygie ther nt,	ပိ	17. Father's Name (First, Middle, Last)		110.2		18. Mother's Na	me (First, Middle,	Maiden Sumame)	oarc
Maryland 21215-0036	iould be filed withi I Mental Hygiene. Narked other than) Be	Durant Hitch				Beulah			
Σ	2 should and Men is marke sumatic	ဥ	19a. Informant's Name/Relationship (T)	vpe. Print)	19b. Maili	na Address (Street a	and Number or F	Rural Route Numbe	er, City or Town, State	Zip Code)
<u>N</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or litems 23a or 28a-1 show eny injury or other traumatic event, the Medical Examiner must be notified at 200ce.		Nancy Lee McNall						, MD 21401	
Baltimore,	Health tam 27 other tr		20a. Method of Disposition	20b.		osition (Name of matory or other place		Date	20c. Location - City	or Town, State
0 L	Pages nent of int: If it iry or o		1 ☐ Surial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Hemovai from State		Cemetery	1	23/06	Salisbur	v. MD
Ē	permit. Pages Department of I Important: If it eny injury or o		21. Signature of Funeral Service Licens							
B	Depa Impo eny ii		Votte K	nine (FSP)	H	lolloway E	funeral	Home Pro	fessional ury, MD 21	Association
			23a. Pert1. Enter the disease, or comp	lications that caused the dea						Approximate Interval Between
	Dhysisian		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.		Necion				Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or as a conse	quence of):	45WI)				
.4	Examiner			225 (5 (6) 25 2 55),55	4401100 01).					
₩	Mer.	er	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	b. Due to (or as a conse	quence of):					
	d d ansit	Examiner	Cause (Disease or injury that initiated events	C						
Ó	ie be executed rsician and e burial-transit		resulting in death) Last	Due to (or as a conse	quence of):		_			
,160,		Cal		d						
Box 68	that the death certificate ed by the attending phys detached for use as the	Physician/Med	IE EENAN E.							
ŏ	th ce tendii r use	an/	23b. was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			23d. Date of o	elivery Day Year
Ш	ed fo	SICI	in the past 12 months? 1 Yes 2 XNo	4 Pregnant at time of 9 Unknown	death 5[Other (specify)			Month	Day 19a
<u>о</u>	at the	Phy	9 Unknown					on- Bids		to the saves of death?
Vital Records, P.O.	signed be de	ρ	Part II. Other significant conditions co	ntributing to death but not re	istiiting in the L	inderlying cause giv	en in Part I.			to the cause of death? Probably 4 Dunknown
ord	w requir been si should	Completed								TODADIY 4 DOTKHOWN
ec	law lasb	nple						24a. Was autor	osy prior t	autopsy findings available completion of cause of
	The page	Cou						1 ☐ Yes	rmed? death	s 2□No
/ita	cian: ertific ector.	Be	25. Was case referred to medical examiner?		110 50 100	0		eath (Check only o	nne)	
	Physician: The lav this certificate has ral director, page 2	ဥ	I LI 162 STANO		ER/Outpatie		4 Nursing		dence 6 Other (S)	pecify)
Division of	ing F	Certification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	k?	28d. Describe	now injury occurred	
Sic	teath tor: the t	cat	2 Accident Investigation 3 Suicide 6 Could not be		homo form et		Yes 2 □ No	28f Location /	Street and Number or	Pural Pouta Number
Σ	I or Attending after death. Director: After in by the funer	irtif	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	efy)	reet, ractory, office		City or To		Tarar House Hamber,
_	pital		29a. Certifier 1 Certifying Phy	ysician: To the best of my kn	nowiedne dea	h accurred at the tin	ne, date and plac	ce, and due to the	cause(s) and manner	as stated
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as it	Medical		iner: On the basis of examin and manner stated.						
	o the o the omple	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
)	⊢ 3 - 8		2 nde Note			Do	57359		March 22	mel 2001
	108		30. Name and address of person who co	completed cause of death (lite	am 23a) (Tuno	1	1,001		March 23	7 7 70 16
	1/0		DR. USHA NATES			S10N 57	SALIS	BURY N	11) 21804	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Pagistrar's Sign		,	1 1 1 1 1	/		
	Registi		MAR 2 2 2	006 Marie	H. L	bank)				
						man stripe - (Males)				

			For Stata Ragistrar	State	of Marylan		artmen rtificat					giene Reg. No.	06	106	No. of Street,
*	Physici	an	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month		Year	3. Time of	
	/Medic		Calvin	Earl			Park:				March	28,	2006	6:40	Рм
	Examir	er	4a. Facility Name (If not institution,	9	imber)			Town, or gers1	Location of	of Death			inty of Death Shingto	n	
	Funeral	The second	1044 Benjamin P 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	r 1 Year	If Under		8. Date of Birt	h		place (State o	r Foreign
	Funeral Director		233-34-2919	1 ∑ M 2□ F		81 Yrs.	Months	Days	Hours	Min.	(Month, Day Sept. 2	y, Year) 27,192	4 We:	st Vir	
	p ,		Usual Residence of Decedent 10a, State 10b, County		100 Cit	ty, Town or Lo	i							0d. Inside Cit	by Limits
	shov	'n	THE STATE OF THE S	• •										1 ⊠ Yes	•
	the N	Director	Maryland Wash:	ington	l F	lagerst	10f. Zip	Code				10g Citizen	of What Cour		, 3
	with the	<u>ā</u>	1044 Benjamin	Place				1742				USA		, .	
	ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	I.S. 13.			spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Americ		
٥	after or Ite		1 Never Married 2 Marrie	Armed F ad 1 23 Yes If Yes, G	2 🗌 No	ĺ	ii τes, spe 1 □ Yes		Specify:		rican, etc.)		Black, White, ec <i>ify:</i> Wh:		h
5-0036	in 72 hours after death with the Maryland "ature!", or Items 23a or 28a-f ehow Isolical Examinar must be notitied at	d by	3X Widowed 4 □ Divorced	Year or I	Dates:										
ζ	n 72 n na n na n na	Completed	15. Decedent' (Specify only highest	grade completed,		16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa ork done d se retired	ition <i>luring m</i> osi)	t of work	ng		f Business/In ed Sta1	,	
7 7	within iene.	omp	Elementary/Secondary (0-12)	College	(1-4or 5+)		ervis		,				Office		
פ	be filed withital Hygiene. d other than	BeC	17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Name	(First, Middle,				
yland	wid be Mental arked c	To E	Norval Ray Par	kinson					Ro	sa I	. Harri	.son			
Mar.	as 1 and 2 should b of Health and Ment litem 27 is marked r other traumatice		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	d Route Numbe	er, City or To	wn, State, Zip	Code)	
-	tealth m 27		Patricia A. McC	onnell/D		1532 Place of Dispo			ew Av		, Hager	stown	Md	21740	
2	if ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation		State	cemetery, cre	matory or o	other place							- "
altimore	permit. Pages 'Department of H Importent: If ite any injury or ot		4 □Donation 5 🛣 Other (Sp 21. Signature of Funeral Service L		oment R	Rest Ha					12006 St Haver		stown,		and
g	Depa Impo any ii		S Mak Si		*						Avenue,				1742
¥.	97.		23a. Part1. Enter the disease, or o	complications that	caused the deat								Jeowii,	Approximate	θ
,	Physician		shock, or heart failure. List of		De ophi	a Gut or	0, 0	OLA	" 1` W 1	# 4 / 4	0			Onset and I	
	/Medical		disease or condition resulting in death)	a. Due to	(or as a donsed	quence of):			× 100	CUVV	L			Jofe	VV
	Examiner		Sequentially list conditions.	b											
	sit ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	puence of):									
	be executed ician end burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	mence of).									
3/60,		Ical E			(0. 40 4 00004	,001100 017.									
) Q	certificate Iding phys	edlc		- a											
XOD	w requires that fhe death certifics been signed by the attending pt should be detached for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		∃Ectopic p	roanana.				23d.	Date of delive	ery	
מ	death he atten ed for u	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (s						Month	Day Y	/ear
r S	requires that the een signed by th nould be detache	Phys	9 Unknown												
Ś	res th signed be de	Ď	Part II. Other significant condition	s contributing to	death but not res	sulting in the u	inderlying o	ause give	n in Part I.				contribute to to	V	leath? Jnknown
ecoras,	requi	eted									-				
ě	has has	Completed									24a. Was autop		Ib. Were auto prior to co death?	psy findings a mpletion of ca	available ause of
Vital		e Co	25. Was case referred to medical			<u></u>			00 Di			200		2 No	
	Physician: this certific ral director,	o Be	examiner? 1 \(\sum \) Yes 2\(\sum \) No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 D0	Othe			n <i>(Check only o</i> me 5 ∑ Resid		Other /Snecii	iv)	
101	g Phys er this eral dir	h:T	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o		28c. Injury Work			28d. Describe h			y /	
Ö	ath. rath. r: After re funer	atlo	1 Accident 5 Pending investig	ation	ioi, Day Tear)	Injury	М		res 2□	No					
UIVISION	r Atte	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 286. Plac	e of Injury - At h ling, etc. (Specia	ome, farm, st	reet, factor	y, office			28f. Location (S City or Tox		umber or Rura	A Route Numi	ber,
2	urs affured or	O													
	Hosp 24 hou Fune fely fi	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the learning of	basis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim i, in my op	e, date an pinion, dea	id place, th occurr	and due to the o ed at the time,	cause(s) and date and pla	l manner as s ce, and due t	tated. the cause(s))
	To the Hospitel or Attending P. within 24 hours atter death. To the Funerel Director: After the completely filled in by the funera	Mec	29b. Signature and title of certifier	anu mai	nner stated.		29	c. License	number			29d. Date si	gned (Month,	Day, Year)	
)	⊢s⊢ŏ		Mara 2001	9 Mu	eh.			D7	836.	<u>-</u> ز	1			-	
	16		30. Name and address of person v	completed cau	s o death (Iter	m 23a) (Type,	Print)	VV		-	r 4	N-112			
	10		MANLA	R J.	1/	PI:	368	nu	u	81-	Ma	JESST	our	274	10
	Sta		31. Date filed (Month, Day, Year)	1	Registrar's Signa	ature		_			(
1	Registr	ar	APR 0 5	2006	20.00	K A	mark.	9							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #23b, nls, 03/22/06, Allegany Co. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** March 21, 2006 06:20 AM William H. Phillips /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Allegany Eckhart
If Under 1 Year | If Under 24 Hrs. 10015 Parkersburg Road Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 M 2 ☐ F Yrs Director Maryland 214-07-3647 18-Aug-1909 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h Counts 28a-f show traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Frostburg Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 10015 Parkersburg Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural, or Itams 23a any injury or other traumatic avant, Itamwilical Examples. 14. Race - American Indian, 21532
13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🜠 No Baltimore, Maryland 21215-0036 Specify Specify: by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) construction homebuilder -12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ Thomas G. Phillips Catherine Isabelle Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12412 Bowling St., S.W. Wayne Droll nephew Cumberland Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 25-Mar-2006 Eckhart Maryland **Eckhart Cemetery** 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Paper. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prostate Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medicai the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2□ No Yes Hospital or Attending Physician: 24 hours after death. Funaral Diractor: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 0 27. Manuer of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nLS MW 7204 3. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0006 Pauline Paone /Medical 4a Facility Name (If not institution, give street and nymber) County of Death 4b. City, Jown, or Location of Death Examiner Cumber Part 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Security Number 6. Sex **Funeral** Days 1 M 2 F Yrs Director 200-28-8609 80 Feb 1. 1926 PA Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28e-f show 1 ☐ Yes 2 ☐ No Director Cambria Northern Cambria 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number other then "naturel", or itema 23a or rent, the Medical Examiner must be 2304 Crawford Avenue 15714 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Registered Nurse Hospital permit. Pages 1 and 2 should be filled. Department of health and Mental Horrimportant: If item 27 ie meritemy or other? 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Clay Joseph Venesky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2304 Crawford Ave.; Northern Cambria, PA Linda Paone--daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 03/18/2006 Northern Cambria, PA 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. for Long-Contres FH 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 Virginia Avenue; Cumberland, MD 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS TWELVE HOURS **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading Lammadian cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown TRACT INFECTION Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No PERIPITERAL VASCULAN GD EMA PULMOINANY 1 Yes 2 No within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 033417 MARCH 12, 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAVALE, MANTLAWD 21502 1063 JAMES R. MUEN NO NATIONAL HIGHWAY 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

			1 - State Registrar	State of Maryland		rtment of Hea tificate of De			iene	6	10650
ı	Physici		Decedent's Name (First, Middle, Last) JOHN THEODORE P.	IPOSZAR, SR.				2. Date of Deat Month MARCH 1		Year	3. Time of Death 10:12 A M
	/Medic Examin		4a. Facility Name (If not institution, give s CHESTER RIVER HOS)			4b. City, Town, or Loc CHESTER			4c. County KENT		
	Funeral Director		5. Social Security Number 6. Sex 1X	7. Age (In yrs. last	t birthday) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, 10 / 24 /	Year) 1946	9. Birthp Cour PA	**
	Maryland a-f show	tor	Usual Residence of Decedent		Town or Loc					1	l0d. Inside City Limits
	3a or 28a	I Director	10e. Street and Number			10f. Zip Code 21651			0g. Citizen of V	Vhat Cour	ntry?
)36	is filed within 72 hours after death with the Maryland I Hygiene. other then "neturel", or items 23a or 28a-f show yent, the Mydical Expiralizations be radified at	by Funeral	383 CYPRESS STR 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:	If	Vas Decedent of Hispa Yes, specify Cuban, M	nic Origin? (Spe Mexican, Puerto l Specify:	cify Yes or No-		k, White,	can Indian, etc.
9500-6121	within 72 houndle.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give I life. D	ent's Usual Occupation kind of work done durin OO NOT use retired)	ng most of worki	ng	16b. Kind of Bu		,
land 2	o d a b	Be	12 17. Father's Name (First, Middle, Last)	4	CER	AMIC ENGI	. Mother's Name	(First, Middle, I	Maiden Sumam		ODUCTION
Maryi	s 1 and 2 should be Health and Menta Item 27 is marked other treumatic ev	70	JOHN PIPOSZAR 19a. Informant's Name/Relationship (Type)			g Address (Street and	Number or Rura		. City or Town,	State, Zip	Code)
_	s 1 and if Health item 27 other tr		MARY PIPOSZAR/W 20a. Method of Disposition	20b. Plac	e of Dispos	CYPRESS sition (Name of latory or other place)			N MD 2 20c. Location -	2165 City or To	
altimore,	permit. Pages Department of I Importent: If it any injury or o		1 ☐ Burial 2 ☒ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State CHE	SAPE	AKE CREMA		/20/06	CHES	STER	, MD
g	Depa Depa Impo any i		Janus Fellows		F:	ellows H 70 W Cypr	Helfenh Tess St			n Fu MD	neralHome 21651
	Pnysician		23a art1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death, le cause on each line. MVLTI OKI			uch as cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequer							24 HRS
	and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Emis Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer							
8/60,	icate be executed physician and s the burial-transit	dlcal	Tooding W Statily East	Due to (or as a consequer	nce or):						
C. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3	Ectopic pregnancy Other (specify)			23d. Dat	e of delive	ery Day Year
rds, P.	w requires that the state of th	by	Part II. Other significant conditions cor	tributing to death but not resulting	ng in the un	derlying cause given in	n Part I.			ibute to th	he cause of death?
I Hecords,	The la ate has page 2	Completed						24a. Whas a autops perform	ned?	Vere auto prior to co leath?	ppsy findings available impletion of cause of
VIta	sician: The certificate lirector, pag	o Be (25. Was case referred to medical examiner?	lospital: 1 2 npatient 2 EP	VOutpatient	Other		n (Check only on		or /Specif	5/1
lon of	Hospitel or Attending Physician: 4 hours after death. Funeral Director: After this certificitied in by the funeral director.	ļ-	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation		Bb. Time of Injury	28c. Injury at Work?		28d. Describe ho			<i>y</i> 7
Division	spitel or Attendi ours after death. nerel Director: A filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (St City or Town		er or Rura	al Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time, o estigation, in my opinio	date and place, a on, death occurre	and due to the ca ed at the time, d	ause(s) and ma ate and place,	nner as s and due to	tated. o the cause(s)
	To the within 2 To the complet	Z	29b. Signature and title of certifier	ula)		29c. License nu			9d. Date signed	(Month,	_
6)	100	30. Name and address of person who co	impleted cause of death (Item 2)	3a) (Type, I	Print)	62423		0-12		005
		ate	Dr. Jennifer de 31. Date filed (Month, Day, Year)	32. Register's Signatur	(002	Church	HIIK	1 Che	sterto	0.	11D 21620
	Regist	rar	MAR 2 1	2006	N.	Salas					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10, 2006 3:30AM M March Mark Robertson George /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Gladys Spellman Nursing Home Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 8, 6. Sex 2 2 F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min Yrs. Texas Director 456-30-6243 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or itams 23a or 28a-f show the Medical Examiner must be notified at XXYes 2 No Director MD Oxon Hill Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 1204 Lindsay Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

XXYes 2 □ No
If Yes, Give
Year or Dates: 53-59 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐XNo Specify: þ 3XXWidowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygient important: if Item 27 is marked other the any injury or other traumatic event, Item 2008. Government Boiler Engineer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth Kingsberry James Robertson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 609 Shelfar Place, Fort Washington, MD 20744 Edwin Robertson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park March 17, 06 Landover, MD 21. Signature Funeral Service License Johnson & Jenkins Funeral Home, INc. 716 Kennedy Street, N.W., Washington, 20011 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ENDOCARDITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed burial-transil Exami ATRIAL FIBRILLATION that initiated events iding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 CONGESTIVE HEART FAILURE Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 1 🗆 Yes 1 ☐ Yes 2 ☐ No 2**X** No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: i or Attending Patter death.

Director: After t After 5 Pending investigation 1XXVatural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospitai **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo. th, Day, Year) 30. Name and address of person who completed cause of death and the second seco 20785 3001 Hospital Srive, Cheverly, MD. Ophnell Cumberbatch, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 2 2006 Registrar

AEM 06-01939

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

thours after death. uneral Director: After the furtion of the furt

within 24 hours a
To the Funeral C

Physician

/Medical Examiner

attanding physicien and for use as the burial-transit

certificate has been signed by the rector, page 2 should be deteched

Examine

Physician/Medical

۵

Be Completed

٩

Certification;

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ate	of Maryland	/ Department	of Health and	Mental Hygiene
		Certificate	of Death	Beg No

And:	re Rich	aro			State of Maryland / Department of Health and N								
			1 - State Registrar					,		rtificat			
			1. Decedent's Nam	e (First, Midd	le, Las	st)							
	Physicia /Medic		Andre	R	ic	hardsc	n						
	Examin	er	4a. Facility Name (f not institutio	ın, give	e street and nu	mber)			4b. City,	Town, o	r Location	of Death
			Prince (George	's	Hospita	1			Che	ever1	Ly	
	Funeral		5. Social Security N	lumber	6. S	ex		e (In yrs. I	ast birthday,	If Under		If Under	
	Director		218-37-	0264	1	M 2□F			21 Yrs.	Months	Days	Hours	Min.
	D		Usual Residence o	Decedent									
	yland 10W		10a. State	10b. County	/			10c. City	, Town or L	ocation			
	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28a-f ehow ite Modical Examiner mink be notified at	Director	DC						Wasl	hingt	con		
	r 28	ire	10e. Street and Nu	mber						10f. Zip			
	th wit		4402 Na	sh St	re	et, NI	2			20	019)	
	dea	Funeral	11. Marital Status			12. Was Dec	edent	Ever in U.:	S. 13.	Was Deced	dent of H	lispanic Ori	igin? (Sp
9	after or its		1 🔯 Never Marr	ied 2□ Mar	rried	1 ☐ Yes If Yes, G		No					
8	er.	þ	3 Widowed	4 Divorced	d	Year or [ve Dates:			1 🗆 Yes	ZL X NO	Specify:	
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death w Heelth and Mental Hygiene. Item 27 Is marked other then "natural", or Iteme 23a other traumatic event, Ite Medical Examiner must b	Completed	(Spec	15. Deceder		ducation de completed,			16a. Dece	dent's Usua kind of wo DO NOT u	al Occup	ation during mos	t of work
7	thin e	ηd	Elementary/Seco	ondary (0-12)	Ť	College (1-4or 5	i+)	life.	DO NOT u	se retired	1)	
21	S S S S S S S S S S S S S S S S S S S	ŏ	11						Ca	rpen	ter		
Þ	il Hygie other	Be (17. Father's Name	(First, Middle,	Last))						18. Mothe	ar's Name
<u>a</u>	S should be filed withir and Mental Hygiene. Is marked other then aumatic event, Its M.	To E	Ronald	Ric	cha	ardson						Fa	ith
<u> </u>	Should had a		19a. Informant's N	ame/Relations	ship (Type, Print)			19b. Maili	ing Address	(Street	and Number	er or Run
ž	and 2 selth an m 27 ls		Faith 1	Robins	sor	n/moth	er		440	2 Na	sh S	Stree	et ₅₀
<u> </u>	es 1 and 2 of Heelth f Item 27 r other tru		20a. Method of Dis					20b. PI	lace of Disponentery, cre	osition (Na	ne of	20	[
2	age anto t: If		1 Burial 2 4 Donation			Removal from	State						_
=======================================	permit. Pages 1 av Department of Hee Important: If Item eny Injury or othe		21. Signature of Fu					ME	. 01:	LVET	Cem	eter	<u>y</u> 3
3a	Dermi Depa Impo eny Ir		21. Signature of Ft	meral Service	LICOI	1300		0	22. Name and Address of Facility HC				
-	d	HUNI	1011		VIITI	10	·		3910	Sil	ver	Hil'	

10g. Citizen of What Country? United States of Hispanic Origin? (Specify Yes or No-Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc.

Black

Specify:

^{Day} 2006

1985

4c. County of Death

Prince George's

11:00 PM

Birthplace (State or Foreign Country)

Wash.,DC 10d. Inside City Limits 1 XYes 2 No

ccupation 16b. Kind of Business/Industry one during most of working etired)

Miles

2. Date of Death

8. Date of Birth (Month, Day, Year)

Jan.1,

Month March 18,

er Private 18. Mother's Name (First, Middle, Maiden Surname)

reet and Number or Rural Route Number, City or Town, State, Zip Code)

4402 Nash Street, NE Washington, DC 20019

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Olivet Cemetery 3/25/06 Mt. Washington, DC 22. Name and Address of Facility Hodges & Edwards F.H.

21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

unshot wali

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year

Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ♥No

3 Probably 4 □Unknown

24a. Was an 1 Yes 2 🗆 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ X es 2 □ No

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☑ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 27. Manner of Death

5 Pending

investigation 6 Could not be determined

28b. Time of 99:32W -18-06

28c. Injury at Work? 1 ☐ Yes 2 SNo

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 5woject shot

28f. Location (Street and Number or Rural Route Number, 5 fix pr Town, State) Luthraiking Ave

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

OCME

29c. License number

29d. Date signed (Month, Day, Year)

March 19, 2006

se of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca-

-HATRICIA 31. Date filed (Month, Day, Year) Registrar's Signature 111 Penn Street Baltimore, Maryland 21201

State Registrar

MAR 2 2 2006



Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Stree

	Ŷ	State Registrar 1. Decedent's Name (First, Middle)	. Last)	_	Cei	rtifica	ite of l	Death		2. Date	Reg. of Death			. Time of De
sicia edica		Cleatrice	Irene	Reid						Month	th 1	Day 2 7	06 /	0:30
nine		4a. Fecility Name (If not institution,		nd number)		4b. City	y. Town, or	r Location of	f Death			4c. County of [Death	
4.7	A'	Doctor's Hosp		7 4 //	- 1 bink d	If I toda	Lan		24 Hrs	0.0-1	(8: #	PG	D	
al or		5. Social Security Number 241-52-5590 Usual Residence of Decedent	6. Sex 1 ☐ M ¾		s. last birthday) Yrs.	Months		Hours	Min.	8. Date (Mont)	of Birth h. Day, Ye 07/19	ar)	Country)	(State or Fo
	_	10a. State 10b. County		10c. (City, Town or Lo	ocation								Inside City L
	ecto	MD PG	·		Bowie									X Yes 2
	Funeral Director	10e. Street and Number 4117 Crosswic	de Truce	n		10f. Z	Zip Code	1 5			10g.	Citizen of Wha	t Country?	
	era	11. Marital Status	12. Was	Decedent Ever in	U.S. 13. V	Was Dec		lispanic Orig an, Mexican,	jin? (Spe	ecify Yes	or No-	USA 14. Race - /	American Ir	ndian.
1	þ	1 ☐ Never Married 2 ☐ Marrie 3 🙀 Widowed 4 ☐ Divorced	ed 1 🗍	ed Forces? Yes 2 ½ No es, Give r or Dates:			acify Cuba	Specify:	, Puerto	Rican, etc	c.)	Specify:	White, etc. Blac	k
	Completed	15. Decedent* (Specify only highest Elementary/Secondary (0-12)	t grade compl		16a. Deced (Give life. I	kind of w	sual Occupa vork done o use retired	during most	of worki	ng	16b	. Kind of Busin	ess/industr	у
	Eo	12th	Coll	ege (1-4or 5+)	Do	mest	tic					Sel	f	
	Be	17. Father's Name (First, Middle, L	,									den Sumame)		
	ပ္	Deviett News	_							e Fo				
Y		19a. Informant's Name/Relationsh				-						ty or Town, Sta		fe)
1	-	Yvonne A. New 20a. Method of Disposition	some	- Siste:	r 4117 Place of Dispo	Cros	SWICK	c Turn	ı; Bo	owie,	Mary	land . Location - City	20715	State
		1 Burial 2 Cremation		from State	cemetery, cren	matory or	r other plac							
	i	4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		Ke	est Hear	Veri (and Addres	ery U.	3/25 /_	/ 2000	6 Wl	Ison, N	orth	Carol
Sign		▶ Chindant		N	D) Pr	TX 416	; Suitl	Free	man F	uneral	Service:	3	
	1	23a. Parkl Enter the disease, or shock, or heart failure. List of	complications	that caused the de								.0732	Apr	oroximate
		SHOCK, OF Heart failure, LIST C			airi. Do not biit	of the inc	ode or dyling	g, such as c	cardiac	i i ospii ati	ory arrest,		1.77	JI OAIIIIALO
۱		Immediate Cause (Final								птөэрпак	ory arrest,		Inte	erval Betwee
# *										л гөэрпак	ory arrest,		Inte	erval Betwee
# *		Immediate Cause (Final disease or condition resulting in death)	a	ue to (or as a conse Conges	RENA equence of): tive f					n respirate	ory arrest,		Inte	erval Betwee
*	iner	Immediate Cause (Final disease or condition resulting in death)	a	ue to (or as a conse Conges ue to (or as a nse	RENA equence of): tive f					птөэрнак	ory arrest,		Inte	erval Betwee
	xaminer	Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	ue to (or as a conse Con 965 ue to (or as a nse	RENA equence of):					птөэрнак	ory arrest,		Inte	erval Betwee
	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a	ue to (or as a conse Conges	RENA equence of):					птөэрпак	ory arrest,		Inte	erval Betwee
	cal	Immediate Cause (Final disease or condition resulting in death) Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	ue to (or as a conse Con 965 ue to (or as a nse	RENA equence of):					птөэрпак	ory arrest,		Inte	erval Between
	cal	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:	a	ue to (or as a conse Con 965 ue to (or as a nse	RENA equence of):					посрыван	ory arrest,	23d Date of	Inte	erval Between
	cal	Immediate Cause (Final disease or condition resulting in death) Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	a	ue to (or as a conse Conges ue to (or as a conse ue to (or as a conse us, outcome of preg Live birth 2 — Fe Pregnant at time of	RENA equence of): equence of): equence of):	Hear	PAI + Fo	ailure		першан	ory arrest,	23d. Date of Month	Inte	rval Betwee
	cal	Immediate Cause (Final disease or condition resulting in death) Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	a	ue to (or as a conse Conges ue to (or as a onse ue to (or as a conse us, outcome of preg Live birth 2 Fe	RENA equence of): equence of): equence of):	Hear Georgical	PAI + Fo	ailure		позрнан	ory arrest,		Inite	rval Betwee
	Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a conseque to (or as a conseque). It is, outcome of pregulation of pregnant at time of Unknown	RENA equence of): chive f equence of): equence of): equence of):	Hear	PAI	ailure			9999-01		delivery	Yea
	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a conseque to (or as a conseque). It is, outcome of pregulation of pregnant at time of Unknown	RENA equence of): chive f equence of): equence of): equence of):	Hear	PAI	ailure		23e.	Did tobacc	Month co use contribut	delivery	Year
	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a conseque to (or as a conseque). It is, outcome of pregulation of pregnant at time of Unknown	RENA equence of): chive f equence of): equence of): equence of):	Hear	PAI	ailure		23e. 24a.	Did tobacc 1 ☐ Yes Was an	Month o use contribut 2 No 3	delivery Day te to the ca Probably	Year Year Year Year
	by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a conseque to (or as a conseque). It is, outcome of pregulation of pregnant at time of Unknown	RENA equence of): chive f equence of): equence of): equence of):	Hear	PAI	ailure		23e. 24a.	Did tobacc 1 □ Yes Was an autoprayed	Month ouse contribut 2 No 3 24b. Werr prior deat	delivery Day te to the ca	Year Year Year Tindings avaition of cause
	e Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a conse Longes ue to (or as a conse ue to (or	RENA equence of): chive f equence of): equence of): equence of):	Hear	PAI	en in Part I.	<u>ت</u>	23e. 24a.	Did tobacc 1 □ Yes Was autopsy performed res 2 1 □	Month ouse contribut 2 No 3 24b. Werr prior deat	delivery Day te to the ca	Year Year Year findings avaition of cause
	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a conseque to (or as a conseque))).	RENA equence of): advence of): equence of): aquence of)	Ectopic John of Share	pregnancy specify cause give	en in Part I.	of Death	23e. 24a. 1	Did tobacc 1 Yes Was an autopsy performed (fes. 2)	Month ouse contribut 2 No 3 24b. Werr prior deat	delivery Day te to the ca Probably e autopsy f to completh? Yes 2	Year Year Year Year findings avaition of cause
	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially flist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a conseque to (or as a conseque). It is, outcome of pregular to the pregnant at time of Unknown If to death but not reference to the consequence	RENA equence of): dequence of): equence of):	Ectopic polytopic solutions of the second sector of the se	pregnancy specify)	en in Part I. 26. Place er: 4 \(\text{Nurse} \)	of Death	23e. 24a. 1	Did tobacc 1 Yes Was an autopsy performed (fex. 2) only one; Residence	Month 2 No 3 2 24b. Werr prior deat	delivery Day te to the ca Probably e autopsy f to completh? Yes 2	Year Year findings avaition of cause
	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Di b Di c. Di d. 23c. If yee 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ue to (or as a consecute to (or as a consecu	RENA equence of):	Ectopic Other (s	pregnancy specify) cause give	en in Part I.	of Death	23e. 24a. 1	Did tobacc 1 Yes Was an autopsy fes 2 Yes only one Residence	Month 2 No 3 24b. Wern prior deat No 1 1 6 Other (standard occurred)	delivery Day te to the ca Probably e autopsy f to complet Yes 2 Specify)	Year Wear Year Year A Dunkr Indings avaition of cause
	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a conseque to (or as a conseque))).	RENA equence of): advence of): equence of)	Ectopic Other (s	pregnancy specify) cause give	en in Part I. 26. Place er: 4 \(\text{Nurse} \)	of Death	23e. 24a. 1	Did tobacc 1 Yes Was an autopsy fes 2 Yes only one Residence	Month 2 No 3 2 24b. Werr prior deat No 1 1 6 Other (:	delivery Day te to the ca Probably e autopsy f to complet Yes 2 Specify)	Year Year 4 Junkn indings avaition of cause
	Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a consequence to	RENA equence of): advence of): equence of)	Ectopic potential of the sector of the secto	pregnancy specify) cause give cause give 28c. Injury Work 1 1 2	en in Part I. 26. Place er: 4 Nur: yat (?) Yes 2 N	of Death	23e. 24a. 1 Very Norther Control of Contro	Did tobacc 1 Yes Was an autopsy (res 2 Yes) Period one Residence In the how in the course of the cause on the cause on the cause on the cause on the cause	Month 2 No 3 2 24b. Werr prior deat 1 6 Other (3 injury occurred	delivery Day te to the ca Probably e autopsy f to complet Yes 2 Specify)	Year Year Year Year Year Application of cause No
	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a consecute to (or as a consecu	RENA equence of): advence of): equence of)	Ectopic polyther (standard) of Market, factor occurrence of the oc	pregnancy specify) cause give cause give 28c. Injury Work 1 1 2	en in Part I. 26. Place er: 4 \sum \text{Nurre} \(\text{At} \) \(\text{Yes} \) 2 \sum \(\text{Nurre} \)	of Death	23e. 24a. 1 Very Norther Control of the Control o	Did tobacc 1 Yes Was an autopsy fes 2 Only Only one) Residence ribe how in ion (Street or Town, St.	Month 2 No 3 2 24b. Werr prior deat 1 6 Other (3 injury occurred	delivery Day te to the ca Probably e autopsy f to complet to complet Yes 2 Specify) r Rural Rot or as stated due to the	Year Wear Year Year A Dunkn Indings avaition of cause No
	edical Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially flist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a	ue to (or as a consequence to	RENA equence of): advence of): equence of)	Ectopic polyther (standard) of Market, factor occurrence of the oc	pregnancy specify) cause give cause give 28c. Injury Work 1 1 2 2ny, office d at the tim on, in my op 9c. License	en in Part I. 26. Place er: 4 \sum \text{Nurre} \(\text{At} \) \(\text{Yes} \) 2 \sum \(\text{Nurre} \)	of Death	23e. 24a. 1 Very Norther Control of the Control o	Did tobacc 1 Yes Was an autopsy performed' (es 2 Yes Control Residence cribe how in ion (Street or Town, St to the cause time, date a 29d. I	Month 2 Use contribut 2 No 3 Use contribut 2 4b. Wern prior deat No 1 Use Contribut 2 and Number of area of place, and place, and	delivery Day te to the ca Probably e autopsy f to comple h? Yes 2 Specify) r Rural Rot due to the	Year Wear Year Year A Dunkn Indings avaition of cause No

		•	For State Registrar	State of Ma	aryland / Dep	artment of I			giene Reg. No.	06	0654
			1. Decedent's Name (First, Middle,	Last)				2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		Turner Rhoades					March	20, 20	06	12:55 p ^M
	Examin		4a. Facility Name (If not institution,	•			or Location of Deat	h		unty of Death	
			Union Hospital			Elkton	If Under 24 Hrs	0 D-1(B)	Cec		Land (Chata as Camina
	Funeral		5. Social Security Number 218-40-0465	6. Sex 7. Ag 1 2 M 2 □ F	e (In yrs. last birthday	If Under 1 Year Months Days		(Month, Da	ay, Year)	Cour	
	Director		Usuel Residence of Decedent		64 trs.			reb. Z	0, 194	Z NOTL	n Carolina
	show		10a. State 10b. County		10c. City, Town or L					1	0d. Inside City Limits
	Mar.	ţo	Maryland Cecil		North E	ast					1 Tes 2XXVo
	in the	ie	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	23a	Funeral Director	64 Belvue Road			21901				States	
	r dez	nue	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of If Yes, specify Cub	Hispanic Origin? (S oan, Mexican, Puer	specify Yes or No to Rican, etc.))- 14.	Race - Americ Black, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 🌠 Divorced	ed 1 ☐ Yes 2 X X If Yes, Give Year or Dates:	40	1 ☐ Yes 2 🔀 No	Specify:		Spi	ec <i>ify</i> : Whi	te
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23a or 28a-t show ha Medicul Erai: in ar rivant te ricitited at	edt	15. Decedent	s Education	16a. Dec	edent's Usual Occu	pation		16b. Kind	of Business/In	dustry
215	72 oir	piet	(Specify only highes Elementary/Secondary (0-12)	grade completed) College (1-4or	life.	e kind of work done DO NOT use retire	during most of wo ad)	rking	State		
21	d with	Completed	10		,	Equipmen			Highw		
	al Hygie d other avant, L	Be	17. Father's Name (First, Middle, I	.ast)				me (First, Middle		тате)	
yla	Ment Ment arke	2	Crommie Rhodes					L. Mart		O 7:-	Co-do)
Maryland	d 2 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic evant, the Men		19a. Informant's Name/Relationsh Rose Lee Poe/Sis			ling Address <i>(Str</i> ee					
	1 and Healt		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date		ion - City or To	
Baltimore,	Pages nent of I ant: It its ury or o		1 ☐ Burial 2 ☐ Cremation	3 □Removal from State	cemetery, cri	ematory or other pla		h 24,	North	East,	Maryland
Ħ	permit. Pag Department Important: I any injury o		' 4 □ Donation 5 □ Other (Sp 21. Signa 19 1 Fun Jan Service I		Ceme	st Method Tery 22. Name and Addr	ess of Facility Cr		neral	Ноте	
Ba	permit. Departr Importa any inji		MHIE!	in l		27 South					1901
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	the death. Do not e						Approximate Interval Between
	Physician	d i	Immediate Cause (Final disease or condition	2	· \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	dime	set-				Onset and Death
	/Medical		resulting in death)	a Due to (or as	a consequence .	صرا ر و	-01				III
	Examiner		Sequentially list conditions	b. Uro	Sessis						
	sit od	iner	Sequentially list conditions, if any, leading to immediate cause. Exter U denying	Due to (or as	a conse luence of):	1	April 1882				
	eath certificate be executed attending physician and for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of:	te u	mbale	nce			
760,	be exician buria	ical E				,					
687	icate phys s the	edic		d							
Box (death certifica e attending ph ed for use as th	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d	Date of deliv	ery
ă	death e atte d for	ic a	in the past 12 months? 1 □ Yes 2 No	4☐Pregnant a		☐ Other (specify)	cy			Month	Day Year
P.0	t the by th ache	Physician/M	9 Unknown	9□ Unknown					-		
	signed I	by P	Part II. Other significant condition	-			iven in Part I.		_		he cause of death?
ord	law requires as been sign 2 should be	ted	End st	oge A	Izheim	5.03		1	Yes 2□N	lo 3 🗌 Prol	pably 4 Unknown
Records	law ras be	Completed	<u></u>					24a. Wa auto	ppsy	prior to co	ppsy findings available impletion of cause of
B	The law cate has I	Con						pen 1 ☐ Yes	ormed? 2LXNo	death?	2 🗆 No
Vital	ding Physician: That. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Ab a a	ath (Check only			
of	physic this al dir	2	1 ☐ Yes 2 No 27. Magner of Death	28a. Date of Inju		ent 3 DOA	4 🗀 14 UI Sillig	Home 5 ☐ Res 28d. Describe			(y)
u.	fter the	tlon	1 Natural 5 ☐ Pendin	g (Month, Da	y Year) Injury	W	ork? □Yes 2□No		,,,,,		
Division	Attending r death. actor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of In	jury - At home, farm,	street, factory, office	9			lumber or Rur	al Route Number,
Div	after Dira d in b	Certification:	4 Homicide	building, e	tc. (Specify)			City of Te	own, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best Exeminer: On the basis and manner s	of examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time	e cause(s) an	d manner as s ace, and due t	stated. o the cause(s)
	ithin 2 o the	Med	29b. Signature and title of certifie		.c.cc.	29c. Licer	nse number		29d. Date s	igned (Month,	Day, Year)
	F ≯ F 8		1 Cakoo	m resp	D	DO	2000	56	3/	21/2	006
			30. Name and address of person	who sampleted cause of	death (Item 23a) (Typ	e, Print)				711	112
			Orden	Coksay	ganik		23 U	Mai	n 58.	FIKK	n, ND.
	Sta Regist	ate rar	31. Date filed (Month Pay. Zear)	2006 32 Aegist	rar's Signature	barle					

			1 - For State Registra MEND#23a(a)peri	State of Marylan MD3/22/06,BMV,McC	d / Depa to <i>Cel</i>	artment of F rtificate of I	leaith and r Death		eg. No.	10655
	Physici		1. Decedent's Name (First, Middle, Last, Eileen Catherine					2. Date of Deat Month March	19, 200	3. Time of Death 1:50P. M
	/Medio Examir		4a. Facility Name (If not institution, give Washington Advent			4b. City, Town, o	r Location of Death	1	4c. County of D	eath
	Funeral Director		5. Social Security Number 6. Se. 10			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day June2, 1		Birthplace (State or Foreign County) ng land
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		y, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	3s or 28	al Dire	10e. Street and Number 8503 Laverne Driv	e		10f. Zip Code	.0873	1	og. Citizen of What United S	country? tates
036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examinations in the notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was DecedenI Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		mencan Indian, /hite, etc. White
Maryland 21215-0036	within 72 ho ene. than "natur he Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired eptionist	during most of wor d)	king	16b. Kind of Busine Dynasty	Construction
nd 2	be filed tal Hygi d other event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, I		vington
ıryla	should be and Mental marked o	7	Patrick 19a. Informant's Name/Relationship (T)		Flynn	ng Address (Street	Mabel and Number or Ru	ral Route Number	City or Town, Stat	
, Ma	and 2 ; ealth ar m 27 is		William T. Rains						aryland 2	
Baltimore,	permit. Peges 1 Department of H Important: if its any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Met	ropoli	esition (Name of matory or other place tan Crema	atory 3/2	1/2006		a,Virginia
Ba	permit Depar Impor any in		21. Signature of Funeral Service Licens	- wast	Ž	onald V. 400 Powde	Borgward MIII R	t Funera oad Belt	l Home, I sville; N	A Maryland 20705
,00	Physician pe executed /Medical Examiner prize the prizer-transit	l Examiner	23a. Part1. Enter the disease, or compliance shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in dealh) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Lasl	Due to (or as a consequence of the consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	uence of):	7 7 (6AS	(/ ATIC!)	or respiratory arm	est,	Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate tate has been signed by the attending physic page 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	Ideath 3	Ectopic pregnancy	,		23d. Date of Month	delivery Day Year
rds, P	quires that in signed b uld be deta	Ď	Part II. Other significant conditions co	ntributing to death bul not res	ulting in the u	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records,	: The law requir cate has been si , page 2 should	Completed						24a. Was a autops perform	ry prior ned? deat	a autopsy findings available to completion of cause of 1? Yes 2 \(\text{NO} \)
Zita Zita	/sicien s certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	lospital: 1 ☐ Inpatient 2 🔀	ER/Oulpatier	nt 3□ DOA Oth	00	th <i>(Check only on</i>	ence 6 ⊡Other (5	Specify)
ion of	To the Hospitel or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor			ow injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Divis	tel or Attanders atter deatlers at Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, elc. (Specif	ome, farm, str y)	eet, factory, office		28f. Location (Si City or Town	treet and Number o n, State)	r Rural Route Number,
	e Hospitel 24 hours a Euneral I	Medical	29a. Certifier Check only one) Certifying Phy 2 Medical Exami	sician: To the best of my kno nar: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	7 Ma		29c. Licens	e number	2	9d. Date signed (M	onth, Day, Year) 21, 2006
	_5		30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type,		110 To	LAMA D	LIMIX	anah
Š.	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 2 2	32. Registrar's Signa	iture	Carlott	MUC. IN	NOW I U	WEINOD.	an Ha

			For State Registrar	State	of Maryla		artment of rtificate o			1ental Hygi	ene	16	06	56
技艺		. ik	1. Decedent's Name (First, Middle	e, Last)						2. Date of Death	1		3. Time of	f Death
	Physici /Medic			Paul Fr	ank Gust	af Roos				Month March	Day 19. 20	Year 006	7:30	A M
	Examin		4a. Facility Name (If not institution	n, give street and	number)		4b. City, Town	or Location	of Death		_	y of Death		
			8500 W	est Howe	11 Road			Bethe	esda			Monte	omerv	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Yea	r If Unde	r 24 Hrs.	8. Date of Birth (Month, Day,	Vosel		lace (State	or Foreign
	Director		None	1 ∑ M 2□I	F 77	Yrs.	Months Day	s Hours	Min.	May 1.	1928		Sweder	1
Т	P .		Usual Residence of Decedent											
	rylar		10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside C	
	B Ma	cto	Sweden No	ne				Upps	sala				1 U Yes	2 X] No
	or 28	Olre	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?	
	23a] B	Sig	gynsväg	22			7544	40			Swed	en	
	dea	ne	11. Marital Status	12. Was E	Decedent Ever in I	U.S. 13. \	Was Decedent of	Hispanic O	rigin? (Sp	ecify Yes or No- Rican, etc.)		ce - Americack, White,		
õ	or it	/Fu	1 ☐ Never Married 2 🌠 Mar	ned 1 ☐ Yes	es 2 🕅 No		1 ☐ Yes 2 X N				Speci		Olc.	
215-0036	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28a-f show ha Madical Examinar mual be moilified at	d b	3 Widowed 4 Divorced		or Dates:		· · · · · · · · · · · · · · · · · · ·		·		Эресі		White	
ភ	72 h	ete	15. Deceden (Specify only highe	t's Education st grade complete	ed)	(Give	dent's Usual Occ kind of work don	e durina mo	st of work	ing 1	6b. Kind of E	Business/In	dustry	
Z	ithin	Idu	Elementary/Secondary (0-12)	Colleg	je (1-4or 5+)	life. I	DO NDT use reti							
N	ygiel ygiel t. th	S			5+		Pro	fessor				niver	sity	
and	be fill d oth	Be	17. Father's Name (First, Middle,	Last)				18. Moth	ner's Name	e (First, Middle, M	laiden Suma	me)		
<u>X</u>	Men Men arke	은		Gustaf	Roos					Gur1i	Svens	son		
<u>0</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Iteme 23a or 28a-1 show any interprofess		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	g Address (Stre	et and Numb	ber or Run	al Route Number,	City or Town	n, State, Zip	Code)	
2	and ealth n 27		Gudrun Roos/	Wife				22 754		psala,				
o c	of H		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 □Removal fr	20b.	Place of Dispo cemetery, cren	sition (Name of natory or other p osala Ky	(ace)			Oc. Location	- City or To	own, State	
Saitimor	Carrier B	1	4 □ Donation 5 □ Other (S		Ga Ga	am⊥a Upj Cem	osala Ky etery	rka	Ap 20	ril 106	Unp	sala.	Swede	an.
a	partr ports y Inji	i	21. Signature of Funeral Service	Licensee	/ .	22	. Name and Add	ress of Faci	ity Ro	ert A. Pi	umphre	v Fun	erall	Iome/
מ	99 = 8) Le sh	A MOO:	335 Be	thesda.	Jnevy Marv1	unas Land	e. Inc. 20814-350	/33/ W 01	iscon	ısın Av	/enue
\$			23a. Part1. Enter the disease, or shock, or heart failure. List	complications th	at caused the dea	ath. Do not ent	er the mode of d	ying, such a	s cardiac	or respiratory arre	st,		Approximat Interval Bet	te
	Physician		Immediate Cause (Final			1	0 11		1. 7				Onset and	Death
	/Medical		disease or condition resulting in death)		rterioso to (or as a conse		c Cardio	vascu	lar I	Jisease		-		
	Examiner				(0. 40 40 00.00	440.100 01).								
		6	Sequentially list conditions, if any, leading to immediate	b. — Due	tu (ur as a cunse	quence of).								
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	•										
	n and	Exa	resulting in death) Last	c. Due	to (or as a conse	quence of):								
00/0	cate be executed physicien and the burial-transit	dlcall		4										
0	ficat g phy is the	g		u.										
× o	The law requires that the death certify late has been signed by the attending sage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregr						23d. D	ate of delive	arv	
ă	atte	clai	in the past 12 months?		ve birth 2 Fet egnant at time of		Ectopic pregnar Other (specify)				1	onth	,	Year
į	y the	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nknown		(
F.	that led b deta	급	Part II. Other significant condition	ons contributing t	o death but not re	sulting in the ur	nderlying cause o	given in Part	I.	23e. Did toba	acco use cor	ntribute to th	ne cause of c	leath?
S S	uires sign d be	d by								1 ☐ Yes	2 ∑ No	3 ☐ Prob	ably 4 □l	Jnknown
ב כ	been	Completed												
ŭ	e lav has	ld III			· · · · · · · · · · · · · · · · · · ·					24a. Was an autopsy perform		prior to co- death?	psy findings mpletion of c	available ause of
77	cate	ပိ								1 ☐ Yes 2	No No	1 Yes	2□ No	
N II G	ding Physicien: The lav.h. After this certificate has funeral director, page 2	Be	25. Was case referred to medica examiner?	-			10		e of Death	Check only one)		Thank	hters
5	Phys this al dir	၉	1 X Yes 2 □ No	-		ER/Outpatien	1 3L DON			me 5 Resider			y) Home	meers
	ing l	Ö	27. Manner of Death 1 X Natural 5 ☐ Pendin	g (A	ate of Injury fonth, Day Year)	28b. Time of Injury	W			28d. Describe how	v injury occu	rred		
200	tend leath tor: ,	Certifications	2 Accident investig	not he				Yes 2						
₹	or Al fter c jirec n by	틭	4 ☐ Homicide determ	ined 288. Pl	ace of Injury - At I uilding, etc. (Spec	nome, farm, stre ify)	eet, factory, offic	В		28f. Location (Stre City or Town,	eet and Num State)	ber or Rura	I Route Num	ber,
ב	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer													
	Host 4 hor Fune ely fi	Medical	(Check only 21X) Medical	Examiner: On the	e basis of examin	owledge, death	occurred at the	time, date a	nd place, ath occurr	and due to the car ed at the time, da	use(s) and m	anner as s	tated. the cause/s	s)
	the I	Med	Cite)	and m	nanner stated.									
	To with	-	29b. Signature and title of certifie		1 . (n	1-1-1	29c. Lice	nse number		29	d. Date signe	ed (Month,	uay, Year)	
•	ic			~	m.0, 10	1		D152	236		Ma	rch 2	1, 200)6
			30. Name and address of person	who completed c	ause of death (Ite	т 23а) (Туре,	Print)							
			Carl I. Margol				le Pike	#211	Rocky	ville, Ma	arylan	d 208	52-314	12
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 2	2006	. Registrar's Sign	ature	800							
	mes a 1510 IS1 (f	-1	IIIMIN W G	LUUU PM	market Sale	ACT OF THE PERSON NAMED IN								

Drianner 388

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HAZEL SMITH 03 В. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BRADFORD OAKS Nursing Home Clinton Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1□M 2□F 217-30-0730 Croom, Marylan Director 88 February 3,1918 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location in than "neturel", or Items 23e or 28e-f show the Medical Examinat must be notified at 10d. Inside City Limits ğMaryland Prince Georges 1. Yes 2 □ No Accokeek Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1208 Teresa Dr. 20607 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item item 27 is merked other then "neturel", or Item other reaumatic event. In Medical Examina 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ð Specify: 3X Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname William Spencer Rena Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Jackson/ Niece 1208 Teresa Dr. Accokeek, Md. 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or otl once. XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection 3/25/2006 Clinton, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility
Alexander S. Pope Funeral Homes, P.A.
5538 Mariboro Pike/Forestville, Md. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Alzheimer's Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause justeds or injury that initiated events Due to (or as a consequence of): Examine requires that the death certificate be executed use as the burial-transi and resulting in death) Last Due to (or as a consequence of): nding physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has autopsy performed? 1 🗌 Yes 2**X** No ths Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident To the Hospitel or Attend within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 035206 tuneny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William T. Tanner, M.D. 11701 Livingston Rd. Ft. Washington, Md. 31. Date filed (Month, Day, Year) Registrar MAR 2 2 2006

		•	For State Registrar	State of Ma	aryland / De <i>C</i>	partmer ertificat			nd Me		giene Reg. No		055	8
			Decedent's Name (First, Middle, Lateral	st)						2. Date of De		Vaar	3. Time of Dea	ıth
я	Physici /Medio		Peter Cli	fford	Snyder	Sr.			N	Month Sarch	20,	2006 Yeer	9:45 A	М
	Examir		4a. Facility Name (<i>If not institution, giv.</i> 10234 Old Fort Roa	ad		Ft.	Wash	Location of ingto:	n		Pr	ince Ge	orge's	
	Funeral Director		5. Social Security Number 6. S 064-30-6447	ex XOXM 2□F	66 Yrs	Months	n 1 Year Days	If Under 2 Hours	Min.	B. Date of Bir Month, Da 01/10/	th 1940	9. Bin	hplace (State or For puntry) SW York	reign
	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28a-f ehow Ita Madical Examinat must be notified at	irector	10a. State 10b. County Maryland Prince Go 10e. Street and Number	eorge's	10c. City, Town or Ft. Was	hingto	n Code				10g. Ci	itizen of What Co	10d. Inside City Li 1 ☐ Yes 2% nuntry?	
	h wit		10234 Old Fort Re	oad			2074	4				USA		
9600	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23s or 28s-1 show way injury or other traumatic event, the Medical Experiment must be notified at ADDE.	Completed by Funeral Director	11. Marital Status 1 Never Married XX Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?	Everin U.S. Nam	3. Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican, Specify:	in? (Spec Puerto Ri	ify Yes or No ican, etc.))-	14. Race - Ame Black, Whit Specify: W		
1215-(within 72 h ane. than "natu	mpiete	15. Decedent's E. (Specify only highest gra		(G	icedent's Usu ive kind of wo e. DO NOT u t.enanc	ork done d ise retired	'uring most)		7		C. Gove	•	
Maryland 21215-0036	id be filed tental Hygie ked other is	To Be Co	17. Father's Name (First, Middle, Last, Peter Clifford	Snyder						First, Middle Larl		n Sumame)		
	nd 2 shoul lith and M 27 is marl r traumati	Ţ	19a. Informant's Name/Relationship (Paul Snyder / Son			-					-	or Town, State, I rgi.nia		
Baltimore,	Pages 1 a ent of Hea nt: if item ry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of Dicemetery, of Marrylan	crematory or	other place	,	Da 03/27			ocation - City or 1tenham	Town, State	d
Balti	permit. Depertm Importal any inju		21. Signature of Funeral Service Lizer			22. Name a	nd Addres	s ol Facilité	Georg	e P. I	Kala	s Funera	al Home P.	
	Physician		Part1. Enter the disease, or complete shock, or heart failure. List on Immediate Cause (Final disease or condition		the death. Do not ne. rosclerot						rrest,		Approximate Interval Between Onset and Deat	
	/Medical Examiner		resulting in death) Sequentially list conditions,	b	a consequence of):									
8760,	ate be executed hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):									
O. Box 6	death certific e ettending p d for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 ⊟Ectopic p 5 ⊡ Other (s						23d. Date of de Month	ivery Day Year	
<u>α</u>	requires thet the een signed by th rould be deteche	ed by Pl	Part II. Other significant conditions of	contributing to death b	ut not resulting in th	e underlying	cause give	on in Part I.			tobacco Yes 2		o the cause of death obably 4 2 Unkn	
Division of Vital Records,	The lar	Completed by						-		24a. Was auto perfo		death?	utopsy findings avail completion of cause 2 No	able ol
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?						of Death	Check only	one)			
on of \	Phy this	2	1 Yes 2 No 27. Manner of Death Natural 5 Pending investigatio	Hospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da			28c. Injury Work	4 🗆 1401		e 5 Resi		6 ☐Other (Spe ury occurred	cify)	
Divisi	ai or Attending s after death. it Director: After id in by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e Diago of Jai	ury - At home, larm c. (Specify)	street, factor	ry, office		28	of. Location (City or To			ural Route Number,	
	he Hospitai n 24 hours a he Funerei I pletely filled	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1	nysician: To the best miner: On the basis of and manner sta	examination and/o	eath occurred r investigation	at the tim	ne, date and pinion, deat	place, an	nd due to the d at the time,	cause(s date an	s) and manner as nd place, and due	s stated. e to the cause(s)	
	To the within 2 To the complet	Ň	29b. Signature and title of certifier			29)c. License	number 45365				ch 20, 2		
f	-(3)		30. Name and address of person who Michael Sidarous	completed cause of d	eath (Item 23a) (Ty)1 #101	pe, Print) Living	ston	Road	Ft.	Washi	ingt	on, MD	20744	
4	Sta Regist		31. Date liled (Month, Day, Year) MAR 2 1 200	2. Registr	ar's Signature	ale								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

10659

3. Time of Death

	Maryland	wode 1-
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Deposition or result and Mental hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Modical Examinar must be notified at

Physici /Medi Examir 1. Decedent's Name (First, Middle, Last)

Depenting 1 (Pages 1 a Dependent of He Dependent of He Important: if item any injury or other pages 1 a Dependent of the Dependent of He Depen

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

an	Orlando Donald Silver,	Sr.		March	12, 2006	6:50 A.M
al er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	r Location of Death		4c. County of Death	1
	Washington Adventist Hospital	Takoma	a Park		Montgome	ery
	5. Social Security Number 577-46-2294 6. Sex 1 1 ★ 2 F 7. Age (In yrs. last birthda 72 Yrs.	Months Davs	ff Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y March 26	9. Birth 6,1933 Was	nplace (State or Foreign untry) hington, D.C.
_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	12	_			10d. Inside City Limits 1 X Yes 2 ☐ No
cto		ington				
Ole e	10e. Street and Number	10f. Zip Code		100	g. Citizen of What Co	untry?
20	1326 Farragut Street, N. W.	200			nited Stat	
Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 ★ Yes 2 □ No Aug • 1953 If Yes, Give Year or Dates: June 1955	3. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 1 No	dispanic Origin? (Sp an, Mexican, Puerto Specity:	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: B1	, etc.
pleted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usuaf Occupive kind of work done e. DO NOT use retire	during most of work	ing U	Sb. Kind of Business/I	nment
mo	12th grade Bin	dery Opera	itor	P	rinting Of	fice
Bec	17. Father's Name (First, Middle, Last)		18. Mother's Nam-	e (First, Middle, Ma	aiden Sumame)	
ToE	Frank Gregory Silver		Gayne1	l Lillie	Carter	
	19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. M.	ailing Address (Street	and Number or Run	al Route Number, (City or Town, State, Z	ip Code)
	Jean Catherine Butler Silver 132	6 Farragut	Street,	N.W.;Wash	ington,D.(C. 20011
	t X Burial 2 ☐ Cremation 3 ☐ Removal from State	sposition (Name of crematory or other pla Heaven Ce		1 18,2006		Town, State ing, Maryland
	21. Signature of Funeral Service Licensee Kannyman Chan	R. N. Hot 600 Kenne	ss of Facility Cton Compa edy Street	any Morti	cians, Inc shington,	
	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each fine.	enter the mode of dyi	ng, such as cardiac	or respiratory arres	t,	Approximate Interval Between
1	fmmediate Cause (Final disease or condition		Onset and Death			
	resulting in death) Due to (or as a consequence of):					
	Stage IV D					
ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
E	that initiated events c.					
Ä	resulting in death) Last Due to (or as a consequence of):					
ca	d					
Med	fF FEMALE:					
ysician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnanc 5 Other (specify)	y		23d. Date of deli Month	very Day Year
유	Part If. Other significant conditions contributing to death but not resulting in the	e underlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ted by	End Stage rend Fo	rilure		1 🗆 Yes	2 No 3 Pr	obabíy 4 Donknown
Completed by Phy				24a. Was an autopsy performe 1 ☐ Yes 2 ☐	prior to d	topsy findings available completion of cause of
Be	25. Was case referred to medical		26. Place of Deat	h (Check only one)		
Tof	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Ott	ner: 4 🗆 Nursing Ho	me 5 Residen	ce 6 □Other (Spec	cify)
tlon:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	ry Wo	yat rk? Yes 2 □ No	28d. Describe how	intury occurred	
ertifica	3 Suicide 6 Could not be determined 28e. Pface of Injury - At home, farm, building, etc. (Specify)	, street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
Medical Certification:	29a. Certifier (Check outy one) 1 Cartifying Physician: To the best of my knowledge, d 2 Madical Examinar: On the basis of examination and/o and manner stated.					
Me	29b. Signature and title of certifier	29c. Licens	se number	171	d. Date signed (Month	n, Day, Year)
	30. Name and address of person who completed cause of death (ftern 23a) (Ty	pe, Print)	hinator	And	entst	Hosn.
te	3. Date filed (Month, Day, Year) 22. Registrar's Signature	VAN	THE PERMIT	- VIOR	11/	110%

DHMH 17 Rev 1/2001

State

Registrar

MAR 2 1 2006

			State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death		2000	10660
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Deat	eg. No.	3. Time of Death
	Physici	an	001	Month	Day Year	9:19 AM
	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Mar.	17, 2006 4c. County of Death	1.1171
	Examir	ner			0 1/1	4 64 4 3
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	9 Date of Birth		DIACE (State or Foreign
П	Füneral		189-07-1477 IMM 20 F QZ Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,		ntry)
	Director		Usual Residence of Decedent	Jept. 1	6,1912 Ha	nover, 17+
	land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	f sh	ō	MD Ballimore Baltimore			1 Yes 2 □ No
	286-	Director	10e. Street and Number	1	0g. Citizen of What Cou	ntry?
	with e or		ZZII W. Rogers Ave ZIZO9	'	11<1	,
	72 hours after death with the Maryland *neturel*, or Items 23e or 28e-f show talical Examiner must be multiked at	Funeral		ecify Ves or No-	14. Race · Ameri	can Indian
	ltem Item	'n	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
36	rs aft	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		Specify:	into
21215-0036	ture F.E.E.	pe	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/In	dustry.
S	d within 72 ho jiene. r then *netui	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	ing		/
12	within lene. then	Ę	Elementary/Secondary (0-12) College (1-4or 5+)		Snack Fo	oods
	filed withi Hygiene. other then		17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, M		
ano	be d la	Be	Paul S Shultz- P.	41.	/-pinnic	V
Ž	should and Men s marke umetic	70	19a. Informant's Name/Relationship (Type, Print) 19b. Maijing Address (Street and Number or Rur.	al Pouto Number	City or Town State Zi	Codol 4.45
Maryland	O1 62 60 50		C D C 1 3 - 7 D G	Uni+#1	NI TIMON	Ium IVID
	s 1 and 2 if Health item 27 i				20c. Location - City or To	21093
ō	S to .		1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State	40	1.1	0,7721
tim	tmen tent:			.21,2006	Hanove	r14 1 1721
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signatur 4 Funeral Service Licensee/ 22. Name and Address of Facility	111.	3490	arusie st.
	α D 25 0 0		Jeglie K./Will Wetzel Luneva	1 Joseph	Inc Hav	10 VEV (41733)
Γ.			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	∍śt,	Approximate Interval Between Onset and Death
	Fnysician	2.0	Immediate Cause (Final disease or condition			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
М	Examiner		Sequentially list conditions. b. A Der Scholler Vasculer hours	ف		
	₽ ≔	Iner	Sequentially list conditions, if any, leading to Entire Underlying Cause, (Disease or injury			
	nd	Examin	trat initiated events C.			
Ö,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed tie has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai	d			
9	ing p	Mec	IF FEMALE:			
Вох	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?		23d. Date of deliv Month	ery Day Year
	e dea	sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		MOUTH	Day Teal
P.0	at the de I by the a stached	Physician/Me	9 Unknown			
	es tha igned I be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to t	
ord	w requir been si should	ted	Values mellies, warmy arty biseese,	1 L Ye	es 2 No 3 Prol	bably 4 Unknown
Records,	lawr as be 2 sh	Completed	Mo Bladder Comes no CITY; 418 Bypass	24a. Was a autops		opsy findings available ompletion of cause of
Ĕ	The lav	mo:	C. m. Wriver - yello ran	perform	ned? death? 2. ☑No 1 ☐ Yes	2 X No
Vital	icien: Th certificate ector, pag	a)	25. Was call ref-rred to medical 26. Place of Death		/	
>	S S	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Reside	ence 6 Other (Specia	fy)
J Of			(Month Flori Voor) Injury What?	28d. Describe ho	w injury occurred	
ō	ath. r: Af	atic	1 ■ Natural 5 Pending (Montin, Day Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No			
Division	er de recto	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	reet and Number or Run n. State)	al Route Number,
	tel or Attending Pt s after death. el Director: After the ed in by the funeral	Certification:	Suitanty, etc. (speaky)	,	.,,	
	ospi hour uner ly fille		29a. Certifier (Check only (Ch			
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	one) and manner stated.			
	To t To t	Σ	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (Month,	
•	10/32		R.T. Filmbons. Darver		3-17-06	3
	VV 4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Liberty, NS. 3708 Back St Balty, N		•	
			ROBERT LIBERTS, MS. 3708 Back ST Balto, N	nd 21	724	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		,	
	Regist	rar	MAR 2 0 2008 Regue & Jack			

			For State Ragistrar	State of	of Marylar		artment of				giene Rag. No.	106	10661
	9 :		Decedent's Name (First, Middle	e, Last)						2. Date of Dea	ath	, T.W	3. Time of Death
	Physici		Elwin Emery Sm	ith						March	15°	2006	10:50 aм
	/Medio Examir		4a. Facility Name (If not institution	n, give street and nu	ımber)	Ctr	4b. City, Town	, or Location	of Death		4c. C	ounty of Death	
			Westminster Nur	sing and	Convale		Westr	ninste	r			Carrol	1
	Funeral		5. Social Security Number	6. Sex 1, M 2 F	7. Age (In yrs.	. last birthday)	If Under 1 Year Months Day		r 24 Hrs. Min.	8. Date of Birti (Month, Day	h v. Year)	9. Birthp Cour	place (State or Foreign
	Director		010-09-3287 Usual Residence of Decedent	X 201	92	Yrs.				August	19 1	918	" Mass
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	ocation					1	0d. Inside City Limits
	Mary Feb	to	NJ Bero	fen		Paramu	s						1X Yes 2 □ No
	h the	irec	10e. Street and Number	<u></u>			10f. Zip Code	•			10g. Citize	on of What Cour	ntry?
	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f show itam while it Extra it is resisted in the interest of the Mariland at the mast continued at the mast continued at the mast continued at the mast continued at the Mariland at the mast continued	by Funeral Director	169 Coombs Dri	ve			07	7652				USA	
	r dea	ner	11. Marital Status	12. Was Dec Armed F	edent Ever in U	J.S. 13.	Was Decedent of	f Hispanic Or uban, Mexica	rigin? (Spe ın, Puerto	ecity Yes or No- Rican, etc.)	14	I. Race - Americ Black, White,	
36	or It	y FL	1 ☐ Never Married 2 ☐ Married 2 ☐ Married 2 ☐ Married 2 ☐ Divorced	If Yes, G	ive		1 ☐ Yes 2 ☐ N					pecify: TAT	hite
215-0036	tural t		1-11-00-00-00-00-00-00-00-00-00-00-00-00	Year or I	Dates:	16a Dece	dent's Usual Occ	unation			16b King	d of Business/In	
15	n "na	piet	(Specify only highe	st grade completed)		(Give	kind of work dor DO NOT use reti	ne during mos ired)	st of worki	ng	Soap		33311,
212	d with giene.	Completed	Elementary/Secondary (0-12)	4	1-4or 5+)		Chemist				Manu	facture	r
	should be filed within and Mental Hygiene. s marked other than "umatic avant, II e Max	Bec	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name	(First, Middle,	Maiden S	итате)	
/lai	should b ind Ments marked umatic a	10	George L. S	mith				M	abel	Patton	-		
Maryland	2 sho and is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stre	et and Numb	oer or Rura	l Route Numbe	r, City or	Town, State, Zip	Code)
	1 and Health tam 27		David E. Smith	/son	200		Brantly Sition (Name of			enwood,		21738	Chata
Baltimore	Pages 1 nent of H ant: If ita		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation	3X☐Removal from	State	cemetery, cre	matory`or other p	olace)				ation - City or To	
tim	t. Pa rtmen rtant: njury		`4 □Donation 5 □Other (S		, wc		Cemeter		3/20,			ett, Ma	55
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant, If a Marical Exercities must be relified at Once.		21. Signature of Funeral Service	A O			riets fo				_	•	
			23a. Part1. Inter the disease, or	complications that	caused the dea		12 Washi					er, MD	21157 Approximate
			shock, or heart failure. List Immediate Cause (Final	only one caus, on	each line.		119	P.	1	_			Interval Between Onset and Death
	Physician /Medical	Н	disease or condition resulting in death)	a. Que to	(or as a conse	quence of).	ulu '	ces	nen	~			WK
10	Examiner			art	trios	cleriot	= Van	-ula	11			3	Boylen
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Qua to	for as a conse	quence of).							
	nd rransi	Examiner	tilat illitiated exellis	o	CV-77	ced	y					2	12 year
,092	cate be executed physician and the burial-transit	Ä	resulting in death) Last	Due to	(or as a conse	quence of):							
687	physic physic the b	dicai		d									
9 ×	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c If yes ou	itcome of pregr	ancy					02	d. Date of delive	
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	al death 3[Ectopic pregnar Other (specify)				23	Month	Day Year
0	the d y the	ysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unkr			3 (0,000))						
0	res that the de signed by the a be detached f	by PI	Part II. Other significant conditi	ons contributing to o	leath but not re	sulting in the u	nderlying cause	given in Part	I.	23e. Did to	bacco use	e contribute to the	he cause of death?
rds	quire: n sig uld biu	q p								1 🗆 Y	es 2	No 3 ☐ Prob	ably 4 Unknown
Records,	aw requir s been si 2 should	Completed								24a. Was a		24b. Were auto	psy findings available mpletion of cause of
R	sician: The law certificate has t irector, page 2 s	mo								perfor		death?	2□ No
Vital	(0	Be C	25. Was case referred to medica examiner?					26. Plac	e of Death	(Check only o	• •		
of V	Physician: r this certificanal director, I	To E	1 ☐ Yes 2 █No			ER/Outpatie	II 3 DOA		lursing Hor	me 5 ☐ Resid	lence 6	Other (Specif	y)
2	ding Physician: n. After this certific funeral director,	ino ino	27. Manner of Death 1 ANatural 5 ☐ Pendir	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	W			28d. Describe h	ow injury	occurred	
sio	Attanding r death. sctor: After by the fune	cati	2 Accident investi	gation not be			1	□Yes 2□					
Division	or At or At Diracl	Certification:	4 Homicide determ	lined 289. Plac	e of Injury - At I ling, etc. <i>(Spec</i>	nome, farm, st ify)	reet, factory, offic	20	1	28f. Location (S City or Tow		Number or Hura	I Route Number,
П	pital ours a aral I		29a. Certifier 1 Cartifyii	ng Physician: To th	a hact of my ke	owledge deat	h occurred at the	timo dato a	nd place of	and due to the	231160(6) 2	nd mannar as s	tatod
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	Examiner: On the I	pasis of examin	ation and/or in	vestigation, in my	y opinion, de	ath occurr	ed at the time,	date and p	lace, and due to	the cause(s)
	ro tha within Fo tha	Me	29b. Signature and title of certifie	· O.			29c. Lice	nse number			29d. Date	signed (Month,	Day, Year)
			Ada WIL	Mr. Lille	1		カフ	544	3		3/1	7/200	4
	MJL		30. Name and address of person	who completed cau	se of death (Ite	m 23a) (Type,	Print)	,	/		UI'-	- 1	
_	·		John W. M	1 deleter	1 68	8 took	Ron	dh	sesta	ninster	71	1D211	57
	Sta	-	31. Date filed (Month, Day, Year,	1	Registrar's Sign	nature	2				/		,
	Regist	rair	WAR 1	6 2006	PROPERTY.	H.	Board "						

			1 - For State Ragistrar	State of Maryla	•		of Health and of Death	Ra	ig. No.	10662
4	Physici /Media		Decedent's Name (First, Middle, La Ruth	Elizabeth		Sen	nler	2. Date of Death Month	Day Yea 24 200	
	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Tov	wn, or Location of Dea	ath	4c. County of De	
	赛 李安	% .	Washington Coun			+	erstown		Washing	gton
i i	Funeral Director			Sex 1 □ M 2 X F 7. Age (In)	rs. last birthday Yrs.) If Under 1 Y Months D	Year If Under 24 Hr ays Hours Min		^{Year)} 1927 Ma	irthplace (State or Foreign Country) aryland
and	M =1		10a. State 10b. County	10c.	City, Town or L	ocation	.,,			10d. Inside City Limits
Na Se	de be	ō	MD Washing	ton	Hagerst	own				1 X Yes 2 □ No
d 21215-0036 filed within 72 bours after death with the Maryland	ital Hygiene. Id other then "natural", or items 23s or 28s-1 show event, the Medical Examiner must be notified at	Director	10e. Street and Number		1148010	10f. Zip Co	ebe	10	g. Citizen of What (Country?
ž.	23a o		372 Radcliffe A	ve.			21740		U.S.A.	
dea	E II	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent	t of Hispanic Origin? (Cuban, Mexican, Pue	Specify Yes or No-	14. Race - An Black, Wh	nerican Indian,
36	a de	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🕅			Specify: W	
21215-0036 d within 72 hours af	ura!	d by	3 XWidowed 4 ☐ Divorced	Year or Dates:	100 David	deethe Herrel O				
ָרָ לְּיֵלְ מַלְיִילָ	u Da	jete	15. Decedent's E (Specify only highest gi	ade completed)	(Give	edent's Usual O e kind of work d DO NOT use ri	lone during most of w	orking	6b. Kind of Busines	s/industry
	P P	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Spre		,	-	Textile	<u> </u>
	nd Mental Hygiene. marked other then imatic event, ine M	a l	17. Father's Name (First, Middle, Las	1)			18. Mother's N	ame (First, Middle, N	faiden Sumame)	
1917	Mental larked of	To B	Robert Henson A	1der			Mary	Ellen Krep	s	
Maryland	and h		19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (St	treet and Number or F	Rural Route Number,	City or Town, State	, Zip Code)
	Health tem 27 other tr		Harold W. Semler				Ave., Ha			
altimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from State	b. Place of Disp cemetery, cre lest Hav	matory or other	r piace)		oc. Location - City of tagers town	
	문문을 .	}	21. Signature of Funeral Service Lice	**				Rest Haven		-
n a	Depa Impo any i		1	3	1	601 Pen	nsylvania			
PI	hysician		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused the do one cause on each line.						Approximate Interval Between Onset and Death
50, be executed III	Medical und parial-transit	licai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a condition of the conditi	pertendence of):	Tibri	llation			
The law requires that the death certificate	by the attending ptrached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	□Ectopic pregn □ Other (specif			23d. Date of d Month	elivery Day Year
ecords, P.	been signed b should be deta	by	Part II. Other significant conditions	contributing to death but not	resulting in the (underlying caus	se given in Part I.		accoluse contribute	to the cause of death? Probably 4 Unknown
Heco The law re	certificate has bee irector, page 2 sho	Completed						24a. Was ar autopsy perform	prior to	autopsy findings available o completion of cause of open serious and serious completions are cause of open serious as a 2 \(\) No
		Be C	25. Was case referred to medicat				26. Place of D	eath (Check only one		-
Vaici	lis ce direc	ToB	examiner? 1 🗌 Yes 2 🗹 No	Hospital: 1 Impatient	2 ☐ ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Reside	nce 6 Other (Sp	pecify)
O C	h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of	of 28c.	Injury at Work?	28d. Describe ho	w injury occurred	
	death. ctor: Af y the fu	atic	2 Accident investigation	on -	,		1 ☐ Yes 2 ☐ No			
Division of Vita	s after de al Directo ed in by t	Certification:	3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	t home, farm, si ecify)	treet, factory, of	ffice	28f. Location (Str City or Town		Rural Route Number,
L Hospital	within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ✓ Certifying P (Check only one)	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, dea iination and/or ii	th occurred at the nvestigation, in	he time, date and pla my opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
Tothe	To tl	Σ	29b. Signature and title of certifier			29c. Li	icense number		d. Date signed (Mo.	
)			1 tank	muly		1	6039	6	3-31	-06
			30. Name and address of person who	completed cause of death (Item 23a) (Type	Print) Car	nt 14	og. Ind	3-31)
	Sta Registi		31. Date filed (Month, Day, Year) APR 0. 5. 2006	32. Registrar's Si	gnature	1		1		

			For State Registrar			nd / Dep		of Hea	alth and N	Mental Hy	_	16	060	53
	Phy	sician	Decedent's Name (First, Classification)							2. Date of De Month		_Year	3. Time of E	
	/M	edical	Snerry L 4a. Facility Name (If not inst	ee Stein	mher)		4b Ciby T	our or lo	cation of Death		29, 200)6 ty of Death	1305	M
	Exa	miner		apeake Medic		tor			cation of Death			larfor	rd	
	Fune	ral	5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday	Bel) If Under 1 Months		Under 24 Hrs. lours Min.	8. Date of Bir (Month, Da	th		place (State or htry)	Foreign
	Direc	tor	212-48-6937 Usual Residence of Decede	1 M 2 XF	53	Yrs.	Widitals	Duy 3	TOUTS INT.	Dec. 5,	1952	Mary	land	
	/land		10a. State 10b. Co		10c. C	ity, Town or L	ocation.						0d. Inside City	Limits
	e Man	ctor	MD Ha	rford	Abe:	rdeen							1 ☐ Yes	2 ⊠ No
	15-0036 72 hours after death with the Maryland "natural", or Itema 23a or 28a-1 show retain the Franche for the state of	Funeral Director	10e. Street and Number 3630 Church	nville Rd.			10f. Zip 0	2100°	1		10g. Citizen of U.S		ntry?	
5	6 after death	Fune	11. Marital Status 1 Never Married 2	Amed Fo	2-7 No	U.S. 13.				ecify Yes or No Rican, etc.)		ice - Americack, White,	ean Indian, etc.	
0	21215-0036 d within 72 hours after giene.	ed by	3 ☐ Widowed 4 ☐ Dive	edent's Education	ates:	160 Dags	1 ☐ Yes 2¾		pecify:		Spec	MIIT		
ω	215-	Completed	(Specify only I	nighest grade completed)	1.40(5+)	(Give	edent's Usual e <i>ki</i> nd of work DO NOT use	done durir retired)	ng most of work	ung	16b. Kind of I	dusiness/In	dustry	
	212 ad wit ygiene	Corr	Elementary/Secondary (0- 12		1-401 34)	Nurs	se				Nurs	ing		
	Maryland d 2 should be file th and Mental Hy stris marked oth tranmatic event	Be	17. Father's Name (First, Mi Robert Lee De					18.		e (First, Middle,				
2	should Me mark	10	19a. Informant's Name/Reia			19b. Mail	ing Address (Street and		ne Finke			Code	
7	and 2: and 2: ealth ar m 27 is		Cary Stein	(Son)		3630) Churc	hvil]	Le Rd.	Abero	deen, M			
166/8	Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If the 27 is marked other than any injury or other traumatic event.		20a. Method of Disposition 1 ☐ Burial 2X☐ Crema 4 ☐ Donation 5 ☐ Oth	tion 3 Removal from er (Specify)	State	Place of Disponentery, creed A. Fe	matory or oth	er place)	3/31,	Date / 06	West C	-		
(1)	Balt permit. Departe Importa	once	21. Signature of Funeral Se	rvice Licensee	now	7	2. Name and Tarri Aberd	Address of ng- (een,	Facility Largo Fi Marylai	ineral of	Home : P 11-3399	.A.		
750	bhysician are be executed hysician and hysician and the burnar-Iransit the burnar-Iransit	er	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Coquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to bDue to c.	(or as a consector as	quence of):		1		ances			Approximate Interval Between Onset and De	eath)
4800	Records, P.O. Box 68760, The law requires that the death certificate be ex the has been signed by the attending physicien is age 2 should be delached for use as the burial	Physician/Mec	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant con	4☐Pregn 9☐Unkno	nirth 2 Feta lant at time of a lown	aldeath 3[death 5[□Ectopic preg □ Other (spec	rify)	Part I	23e Did to		ate of deliver	Day Ye	
#8	cords, w requires to been signal should be	5		3.2			-	35 917011111			es 2□No		ably 4 Uni	1
hus		e Completed	25. Was case referred to me	dical					Di		sy med? 2XINo	Were autoprior to cordeath?	osy findings av npletion of cau 2 No	allable se of
Z	f Vi nysicia nis cer direct	10 B	examiner? 1 ☐ Yes 2 No	11 11	npatient 2] ER/Outpatier	nt 3 DOA			n <i>(Check only o</i> me 5 □ Resid		ner (Specifi	·)	
5	Division of Vita To the Hospital or Attending Physician: To the Hospital or Attending Physician: To the Funeral Director: After this cartifical completely filled in by the tuneral director.			ending (Moni		28b. Time o Injury	f 280	linjury at Work? 1 ☐ Yes		28d. Describe h	ow injury occu	rred	,	
ein	Divisic tal or Attenders after death at Director: ed in by the	<u></u>		28e. Place building	of Injury - At h ng, etc. (Speci	nome, farm, sti ify)	reet, factory, o	office		28f. Location (S City or Tow	treet and Num. n, State)	ber or Rura	Route Numbe	W,
5	To the Hospital of within 24 hours at To the Funeral D completely filled i	Medical	29a. Certifier 1 Cer (Check only 2 Med one)	tifying Physician: To the lical Examiner: On the ba and mann	best of my knoasis of examination stated.	owledge, deat ation and/or in	h occurred at vestigation, in	the time, d my opinio	ate and place, n, death occurr	and due to the cred at the time, c	ause(s) and m date and place,	anner as st and due to	ated, the cause(s)	
	To t withi To tl	Σ	29b. Signature and title of ce	entifier	com		29c. L	icense nui	mber	,	29d. Date signe	ed (Month, i	Day, Year)	
	•		20 No.	acr	- 12 2 2 2			104	8-4	1	3/3	0/0	6	
	6	State	AShkan B 31. Date filed (Month, Day, -)	ahrani, n	e of death (Item).D. S egistrar's Signa	11450	undpi	per (irde,	Ste. 2	H Bal	timo	(e,MD	2123
	47475 A	istrar	APD (5 2006		H L	and I						,	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2<u>006</u> Physician Year MARCH 18, 2225 Straw Emma Gray /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL & MEDICAL CENTER 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🗓 F Yrs 235-32-1199 Director 08/22/1911 Pennsylvania Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic evant, the Medical Examinar must be notified at 1 ▼Yes 2 No Directo Allegany MD Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Baltimore Street 21502 USA death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itar any injury or other traumatic evant, the Medical Examinat once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 3 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McKinney (NMN) Harry Allison Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19924 Chesley Knoll Drive, Gaithersburg, MD20879 Saundra M. Rebholz / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State * 4 □ Donation β □ Other (Specify) 03/22/2006 Hillcrest Mem. Park Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Concestive Heart Failure 1 day /Medical Due to (or as a consequence of): Examiner Acute Myocardial Infarction 24 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Hypertension, Hyperlipidemia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes or Attanding Physician: after death. Diractor: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours at To the Funeral Di 29a. Certifiei 1 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5 D46346 21, MARCH 2006

State Registrar

DHMH 17 Rev 1/2001

625 Kent Avenue, Cumberland, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

3. Registrar's Signature

Huma Shakil,

31. Date filed (MARPa)

			For State Registrar	State of Maryla	•	artment of H rtificate of L		-	giene Reg. No.	06	10665
	Physici	20	1. Decedent's Name (First, Middle, Las	st)				2. Date of De.		Year	3. Time of Death
	/Medic		KATHRYN W. STEV						16, Day 20		5:50 P M
	Examin	er	4a. Facility Name (If not institution, giv ST VINCENT de PA		NTER	FROSTBL			ALL	EGANY	
	Funeral Director		212-24-1087	ex 7. Age (In yrs 85	. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 15-Jan-		9. Birthpl Coun Mary	ace (State or Foreign try) land
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10	Od. Inside City Limits
	Aaryli F sho	ō	Maryland Allega		stburg						1 X Yes 2 □ No
	the A	Director	10e Street and Number		stourg	10f. Zip Code			10g. Citizen	of What Coun	try?
	3a or	0	205 East	Street		21532-			USA		
	death	Funeral	11. Marital Status	12. Was Decedent Ever in I	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No		Race - Americ	
9	or Ite	/ Fu	1 Never Married 2 Married	1 Yes 2 No		il Yes, specify Cuba 1 □ Yes 2 ☑ No	Specify:	nican, etc.)	Spe	Black, White, e	€1C.
9	Jural',	d by	3 Widowed 4 □ Divorced	Year or Dates:		(1				White	
21215-003	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Modical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest gradual)	ducation de completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of work	king	16b. Kind of	Business/Inc	lustry
7	withii ene. than	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		ptown Elem			educati	ion	
	filed Hygi othar	Be C	17. Father's Name (First, Middle, Last,	4	T CIESA	Drown Dien	18. Mother's Nam	e (First, Middle,			
<u>a</u>	Duld be Mental arked o	To B	Arthur E. Wonn				Gertrude	Renhann			
Maryland	ges 1 and 2 should be filed within to of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Merical Country or other traumatic events.		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street a	and Number or Rui		er, City or Tov	wn, State, Zip	Code)
	1 and Health am 27 ther tr		Jay Stevens	Son		Piney Mount	1.10	stburg		yland	21532
altimore,	Pages 1 nent of H int: if ital iry or otl		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □	Removal from State	cemetery, crei	Name of matory or other place	1	Date		on - City or To	wn, State
	t. Pa rtmen rtant: rjury		`4 □Donation 5 □Other (Specif	1.00	khart Cen			Mar-2006	Eckhart	Ma	ryland
Ba	permit. Page Department of Important: if any injury or		21. Signature of Funeral Service Lice	Keenst	- 24	2. Name and Addres Durst Funera		Frost Ave.,	Frostbur	g, MD 2	1532
			23a. P. T. Enter the disease, or comock, or heart failure. List only Immediate Cause (Final	one cause on each line			-	or respiratory as	rrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Renal Due to (or as a conse	equence of):	achie					Lyears
	Examiner			Diali	eles	. Mell	le hus				
L,		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						
	ecute ind trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	-0						
60,	oe excian a		resulting in death, East	Due to (or as a conse	iquence or):						
68760,	icate be executed physician and s the burial-transit	edical		d							
_	ding se a	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d.	Date of delive	rv
Вох	death e atten ad for u	O	in the past 12 months?	1 ☐ Live birth 2 ☐ Fei 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)					Day Year
0.	t the by the lacher	Physl	9 Unknown	9□ Unknown							
	law requires that the de as been signed by the s 2 should be detached f	by Р	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use c		e cause of death?
Vital Records,	w require been si should b		Diaretes	Metal	3			10`	res 21 No	3 Prob	ably 4 Unknown
မင္ပ	lawras be	Completed						24a. Was autor	osy	prior to con	osy findings available npletion of cause of
<u> </u>	The sate has page	Con						perfo 1 ☐ Yes	rmed? 2 No	death? 1 ☐ Yes	2 No
VII 3	Physician: The lar this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Dear				
	g = g	To I	1 Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time o	nt 3 DOA	Nursing H	ome 5 Resident			")
	ding I h. After funer	tlon	Natural 5 Pending	(Month, Day Year)	Injury	Work	(? Yes 2'□No		ion injury out		
Division of	or Attanding after death. Director: After in by the fune	ertifications	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Injury - At		reet, factory, office		28f. Location (S	Street and Nu	mber or Rura	Route Number,
5	tal or A	Cert	- Institute	building, etc. (Spec	··· f /			J., G. 101			
	To the Hospital of within 24 hours at To the Funaral D completely filled in	edical		nysicien: To the best of my kr niner: On the basis of examin and manner stated.							
	Fo the within Fo the	Me		H. Cholani		29c. License	number		29d. Date şig	ned (Month, I	Day, Year)
•	3		•	H. Chaclant		D	58853	3	3/	20/0	6
	n ks		30. Name and address of person who		em 23a) (Type.	Print)	tve, C	umb	erla	nd,	MD 21502
Ī	Sta		31. Date filed (Month, Day, Year)	32 Aegistrar's Sign		0.0%				-	

			1 - For State Registrar	State of Ma	aryland / De <i>C</i>	partmer ertificat			l Mental Hy	giene Reg. No.	06	10666
	Physic	an	Decedent's Name (First, Middle, Las	t)					2. Date of De Month	Day	Yeer	3. Time of Death
	/Medi	cal	Mary Jane Skidmor 4a. Facility Name (If not institution, give	e street and number)		4h City	Town or I	Location of De	03_	19 4c Cour	06 Ity of Death	0140 M
	Examir	ıer	Sacred Hea		pital			rland	,		egar	14
	Funeral		Social Security Number 6. S	7. Ag	e (In yrs. last birthda	Months	r 1 Year Days	If Under 24 H Hours Mi		th		place (State or Foreign
	Director		215-14-6187 Usual Residence of Decedent	□M 2 /X F	_86Yrs				06-No			yland
	/iand		10a. State 10b. County		10c. City, Town or	Location				<u> </u>	1	0d. Inside City Limits
	a-feh	ctor	Maryland Allega	inv.	Frostburg							1 ☐ Yes 2 No
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f ehow ent, the Madical Examinar must be notified at	Director	10e. Street and Number	Voodview Driv		10f. Zij	Code	-		10g. Citizen o	f What Cour	ntry?
	eath v	Funeral	11. Marital Status	12. Was Decedent		3 Was Dece	1532-	nanic Origin?	(Specify Yes or No	U.S.A.	ace - Americ	an Indian
9	after d or sten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1 1 1		If Yes, spe	cify Cuban	, Mexican, Pu	erto Rican, etc.)			etc.
9	ural', c	d by	3 N Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 NO	Specify:		Spec		
21215-0036	"nati	Completed	15. Decedent's Ed (Specify only highest grades)		(G	cedent's Usu ive kind of wo e. DO NOT u	ork doné du	uring most of w	vorking	16b. Kind of	Business/in	dustry
72	I withii lene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5	5+)		Í			1	1	
<u>p</u>	al Hyg lothe vent,	BeC	17. Father's Name (First, Middle, Last)	V	noi	memake		18. Mother's N	lame (First, Middle	homen Maiden Suma	ame)	
<u>yla</u>	should be ind Mental in marked or	To	George Taylor					Ellen 7	Tavlor			
Maryland	hand hand 7 ie m traum		19a. Informan's Nam - Relationship (7	урө, Print)				nd Number or	Rufal Route Numb	er, City or Tow	n, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any follury or other traumatic event, the Medical Examiner must be notified at ance.		William Skidmore 20a. Method of Disposition	son	20b. Place of Circle cemeter).	18 McM		R	Cawllings Date	Mar 20c. Location	yland 1 - City or To	21557 own, State
Baltimore,	Pages nent of I int: if its iry or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Restlawn			1	22-Mar-2006	LaVale	M	aryland
alti	permit. Departm Importa any inju		21. Signature of Funeral Service Licen	580	Restiawii	22. Name ar			22-Wiai-2000	Lavaic	191	en ylane.
_	20E # 9		John R.	Mury					57 Frost Ave		rg, MD	
			23a. Part . Enter the disease, or comp slock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	ne.		de of dying.	, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Aca	a consequence of):	inhil	n	fante	Les			hours
	Examiner		Commentation for any distance	b 550 to (01 45	a consequence on.							
	pg sit	iner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	а сопѕециэнсе of).							
	sate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	_					-	
8760,	e be e sician e burit	dicai E		ď								
9	nificate ng physi as the b	Medi	IE ECHALO:	V								
Вох	leath certific attending p	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic p	regnancy				ate of delive	Day Year
0	the a	Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of death	5 ☐ Other (sp	pecify)					Day Four
<u>م</u>	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	by Ph	Part II. Other significant conditions co	entributing to death b	ut not resulting in the	underlying o	ause giver	n in Part I.	23e. Did t	obacco use co	ntribute to th	ne cause of death?
rds	en sig ould b	ed b	Ca of colon	,	ant	Pront	into	ter	10	Yes 2□No	3 ☐ Prob	ably 4 Mnknown
ဓင္ပင	has be ge 2 sho	Completed	- Hy pertermin	a ar	eins	con	house		24a. Was	an 24b	. Were auto	psy findings available mpletion of cause of
<u>س</u> ح	Physician: The la r this certificate has ral director, page 2	Con	enten a se	ose,					perfo 1 ☐ Yes	rmed?	death? 1 ☐ Yes	
<u> </u>	sician	Be c	25. Was case referred to medical examiner?	Hospital:	-5		Othor		eath (Check only o			
ō	Attending Physician: ir death. ector: After this certifics by the funeral director, is	n: To	27. Manner of Death	28a. Date of Inju. (Month, Day			28c. Injury a Work?	4 Nursing	Home 5 Resi			<u>r)</u>
Ö	uttending death. ctor: Aft y the fun	atio	1 Natural 5 Pending 2 Accident investigation		<i>y Year)</i> Injur	м		es 2□No				
Division of Vital Records,	or Atta	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubul	ury - At home, farm, c. (Specify)	street, factor	y, office		28f. Location (City or To		nber or Rura	l Route Number,
	pitai ours a ours a leral [29a. Certifier Certifying Phy	sician: To the best	of my knowledge, de	ath occurred	at the time	date and pla	ce, and due to the	cauco(s) and s		atad
	To the Hospital or Attending Ph within 24 hours aftar death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Examone)	iner: On the basis of and manner sta	examination and/or	investigation	i, in my opi	nion, death oc	curred at the time,	date and place	a, and due to	the cause(s)
	To ti To ti	Ž	29b. Signature and title of certifier			29	c. License	number		29d. Date sign		
	5		em				212	44		3/19	9/20	06
	nas		30. Name and address of person who o	11 2	1 -	- 41		M.		215	20	
14	Sta		31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	ros7 10	urq	, lan	grand	×10	J.×	
	Registi	ar	MAR 2 0 200	0	- Al fa	03000	V					

Amended Part II, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03/17/06, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 03 11:15 AM ELIZABETH SEEDERS MABEL 03 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOSPITAL ALLEGANY ACRED HEART CUMBERLAND | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV 1, 1920 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 85 236-76-2223 WEST VIRGINIA Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d, Inside City Limits or 28a-f ehow The Medical Examiner must be notified at 1 ☐ Yes X☐ No WV MINERAL RIDGELEY Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 26753 PENNSYLVANIA STREET U.S.A. or iteme 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3℃ Widowed 4 Divorced Year or Dates 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If itsm 27 is marked other the eny injury or other traumatic event, I'ms 2006. DRAPERY SEAMSTRESS 8 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Be CLARE ELWOOD WAGONER MARTHA EMMALINE GARLAND ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM E. SEEDERS / SON P.O. BOX 450, RIDGELEY, WV 26753 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State RESTLAWN MEML.GARDENS 03/06/2006 4 ☐ Donation 5 ☐ Other (Specify) LAVALE, MD 21. Signature of Funeral Serviçé Licensee UPCHURCH FUNERAL HOME, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21502 202 GREENE STREET, CUMBERLAND, Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** weeles rope /Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 1 ☐ Yes 2 ☐ No 20 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 ☐ Yes 2 No 1 Anpatient 3 DOA 2 ER/Outpatient 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 1-ENatural 2 Accident 5 Pending investigation M 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) completely 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2006 00033280 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dunil

DHMH 17 Rev 1/2001

Johnson Heights Medical Building

Registrar's Signature

OM

GUPTA,

31. Date filed (Month, Day, Year)
MAR 1 7 2006

Comberland,

WD

			1 = For State Registrar	• •		d / Depa	artment		and M	dental Hyg	_		10668
	G .		Decedent's Name (First, Middle,	Last)					-	2. Date of Dea Month	th	Van	3. Time of Death
	Physicia /Medic		Joseph Swyka							MARCH	19, 20	OO6	04:30A M
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, T	own, or Location	of Death		4c. County	of Death	1
			VA MARYLAND HEA			to an in internal color		Y POINT	r 24 Hrs.	O Date of Birds	CECI		
	Funeral Director		5. Social Security Number 180-14-7649 Usual Residence of Decedent	6. Sex 1 X 1 M 2□ F	7. Age (In yrs.	2 Yrs.		Days Hours	Min.	8. Date of Birth (Month, Day January	Year) 8,1924		place (State or Foreign intry) aryland
	yland now		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
Æ	ours after death with the Marylar ral', or Itams 23a or 28a-f show Exarither and be putified at	ctor	MD Cec	il		Chesape	eake C	ity					1 ☐ Yes 2 🕱 No
SWYKA	ith th or 28	Director	10e. Street and Number				10f. Zip 0	Code		1	0g. Citizen of	What Col	untry?
	s 23a	ral	44 Forest Lane	10 Wee Dee	edent Ever in U	S 112		915	rising (Co	acifu Van ar Na	USA	Amar	ican Indian,
H	ter de iner	Funeral	11. Marital Status 1 □ Never Married 2 Marrie	Armed Fo	orces?	ĺ				ecify Yes or No- Rican, etc.)		ck, White	
JOSEРН 0036	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Ves Gi	ve Dates:WW 11	[1 ☐ Yes 2	No Specify	y:		Specif	y: Wh.	ite
EKNOWN TO PHYSICIAN: JOSE Baltimore, Maryland 21215-0036	2 should be filad within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic svent, Ita Modical Examither mat be notified at	Completed	15. Decedent' (Specify only highest			16a. Dece	dent's Usual	Occupation	st of work	ina	16b. Kind of B	usiness/l	ndustry
24 Z	vithin ne. han "	npl	Elementary/Secondary (0-12)	1	1-4or 5+)			done during mo retired)			21		
PHYSICIAN Iryland 212	filad v Hygie other t	S	17. Father's Name (First, Middle, L	asti		Met	Uwrig		her's Name	e (First, Middle,	Chem.		
ZSI and	be be	o Be	Leon Swyka	2017					ry Le	, , ,			
PH	shoul nd Me mark mark	٦ 2	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address (_	w a <i>l Route Numb</i> ei	, City or Town,	State, Z	ip Code)
D. N.			Alice Mary Swyl	ka/wike		44	Fore	st Lane.	Che	sapeake	Citu.	Maru.	land 21915
N 1	as 1 and of Health fitem 27 r other t		20a. Method of Disposition 1 Burial 2 □ Cremation			Place of Dispo	sition (Name	e of		Date	20c. Location	City or 7	Town, State
S E	permit. Pagas Department of Important: If i any injury or once.		¹ LABurial 2 ☐ Cremation ¹ 4 ☐ Donation 5 ☐ Other (Sp		State St.	Rose	of Lin	na	03-2	4-2006	Chesan	eake	City, MD
at E	permit. Departr importa any inji		21. Signature of Funeral Servee L	icensee		0.	2. Name and	Address of Faei	MyR.T	. Fourd	Funera	c Hoi	ne, P.A.
NAME KNOWN Baltimor	20 E 20 20		100			31	8 Geo	rge St.,	. Che	sapeake	City,	MD :	21915
NA				complications that only one cause on	caused the deat each line.	h. Do not en	ter the mode	of dying, such a	s cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immedial Cause (Final diseas r condition resulting in death)	u	KINSON'S		ASE						UNKNOWN
	Examiner		V	Due to	(or as a conseq	uence of):							
	100	ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):						_	
2	be exactited sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	c.									
0	e experien ar	Ĕ	resulting in death) Last	Due to	(or as a conseq	uence of):							
8760	e % e	lical		d							· · · · · · · · · · · · · · · · · · ·		
89 x	death cartificat e attending phy d for use as th	Physiclan/Med	IF FEMALE:	22c Hives o	stcome of pregna	2004					2018		
Вох	attend for us	slan	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	Il death 3	Ectopic pre Other (spe				1	te of deli- onth	very Day Year
P.O.		ysic	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unkr		Joann J.	_ Other (ape	Giry)					
	Physician: The law requires that the this certificate has been signed by the rat director, page 2 should be detache	by Ph	Part II. Other significant condition	ns contributing to o	death but not res	ulting in the u	ınderlying ca	use given in Parl	t I.	23e. Did to	bacco use con	tribute to	the cause of death?
rds	w requires that baen signed is should be det									1 🗆 Y	es 2□No	3 🗆 Pro	bably 4X Unknown
S S	aw re	Completed								24a. Was a	in 24b.	Were aut	topsy findings available ompletion of cause of
ž	The lay ate has page 2	mo:								perfor	med?	death?	2 No
ita	iician: The certificate ha rector, page	Be C	25. Was case referred to medical examiner?						ce of Deat	h (Check only or			
<u>></u>	Physic this ceral dire	2	1 ☐ Yes 2 🛣 No		Inpatient 2		_		Nursing Ho	ome 5 Resid			ify)
Z Z	ding P h. After t funera	lon:	27. Manner of Death 1 Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury		lc. Injury at Work? 1 ☐ Yes 2 [JNo.	28d. Describe h	ow injury occur	red	
Division of Vital Records,	death death stor: ,	Certification:	2 Accident investig 3 Suicide 6 Could n	ot be Ope Plac	e of Injury - At h	ome farm st	M reet factory		7140	28f. Location /S	treet and Numi	ber or Ru	ral Route Number,
Οį	i or Attene after deatl Director: I in by the	ertil	4 ☐ Homicide determi	ned build	ting, etc. (Specil	(y)	icot, idotory,	omeo		City or Tow	n, State)		,
	Hospita 4 hours Funeral	edical C	29a. Certifier 1 X Certifying (Check only one) 2 Medical E	g Physician: To th Examiner: On the to and mar	e best of my kno casis of examina nner stated.	owledge, deal ation and/or in	th occurred a nvestigation,	t the time, date a in my opinion, de	and place, eath occur	and due to the or	ause(s) and m late and place,	anner as and due	stated. to the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c.	License number	r	2	9d. Date signe	d (Month	, Day, Year)
	- > - O		Join	41 2h	ang		VV	0101058	0281		03/19/0	06	
		1 17	30. Name and address of person v	1	1	n 23a) (Type.		.0101000	JZUI	5.00	03, 13, 0		
		13	co. reality and addition of portion.				1 11111/						
10	TIVA	18	JIANYI ZHANG, M. 31. Date filed (Month, Day, Year) MAR 2 2	D. VA M		HEALT		E SYSTEM	, PEF	RRY POIN	T, MD 2	1902	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) MARCH 21, **Physician** 2006 JOAN KAY SPARROW 07:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 312 MERRICK CORNER ROAD CHURCH HILL OUEEN ANNE'S If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth AUGUST 17, 1936 9. Birthplace (State or Foreign Country) NY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1 ☐ M 2 💢 F 69 212-34-7456 Yrs Director Usual Residence of Decedent death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Itams 23a or 28a-f shor The Medical Evarines must be notified at MD QUEEN ANNE'S CHURCH HILL 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21623 312 MERRICK CORNER ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itam any injury or other traumatic event, the Medical Eventnessing. Black, White, etc. 1 Never Married 2 Narried WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Be Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLOTTE BROCKMAN GLEN DELANO LOPUS 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 755 APPLETREE LANE, MT. WOLF, PA MARK SPARROW/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State CHESAPEAKE CREMATION 103/22/3006 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD, CHESTERTOWN, MD 21620 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heart fer, usderokic Pnysician 600 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. East of Jerry Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months?
1 Yes 2 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 No or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 No in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To tha To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 139996 Drive Charles, Mis 2/6/9 30. Name and address of p rson who completed cause of death (Item 23a) (Type, Print) O. Done ho 2108 (200 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma		epartmen Ce <i>rtificati</i>			nd Me		iene	06	10670
¥	Physici /Medio		1. Decedent's Name (First, Middle, Last) Bernadette Steven	s						2. Date of Deat Month March	Day 16	2006	3. Time of Death
40.	Examin		4a. Facility Name (If not institution, give s Riva Terrace III				Anr	Location of napoli	.s			unty of Death	
**************************************	Funeral Director		5. Social Security Number 201–12–0857 Usual Residence of Decedent	7. Age	a (In yrs. last birth 85 Yı	Months	Days	If Under 2 Hours	Min.	B. Date of Birth (Month, Day, May 6,			ace (State or Foreign try) nsylvania
	a-f ehow	ctor	Maryland IOb. County Maryland Anne Ar	undel	10c. City, Town	or Location	Ec	igewat	er			10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number			10f. Zip	Code			1	_	of What Coun	try?
	s 23s	erai	2808 Caraway Court		i= 11 6	12 W D	44	210		if . Von No		S.A.	an Indian
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 te marked other then "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	1	13. Was Deced If Yes, spec 1 ☐ Yes		n, Mexican, Specify:	Puerto R	ican, etc.)		Black, White, e	
Maryland 21215-0036	thin 72 ho e. en "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade			Decedent's Usua Give kind of wor life. DO NOT us	k done d	during most	of working	9	16b. Kind o	of Business/Ind	lustry
7	led wii ygien her th it, the	Con	Elementary/Secondary (0-12)			Home	make					Home	
yland	ould be fill Mentat H harked off	To Be	17. Father's Name (First, Middle, Last) Harry J. Johnson					Ca	ther	ine F.	Igoe		
	and 2 sh selth and n 27 le m sr traum		19a. Informant's Name/Relationship (Typ. Joanne Bast/daug		28	Mailing Address 108 Cara	way	Court		Route Number, gewater			²¹⁰³⁷
nore	Pages 1 and of He int: If iten		20a. Method of Disposition 12○Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Cometery,			1	Da			on - City or To	
Baltimore,	permit. P. Departme Important any injury		4 Donation 5 Other (Specify) 21. Signatur Funeral Service License	file	Holy Se	22. Name an	d Addres	s of Facility	Jol	20/06 nn M. Ta	aylor		
	Physician		23a. Part1. Enter the disease, or complies shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each lin	the death. Do no	t enter the mod							Approximate Interval Between Onset and Death Months
8760,	/Medical Examiner whysicien and the prijal-transit	icai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence of	E.							
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐Ectopic pr 5 ☐ Other (sp					23d.	Date of deliver Month	ry Day Year
	quires that in signed bi uld be deta	þ	Part II. Other significant conditions con	tributing to death bu	it not resulting in t	he underlying c	ause give	en in Part I.					e cause of death?
Records,	The law requir tte has been si vage 2 should l	Completed			-					24a. Was ar autops perform	red?	tb. Were autop prior to corr death? 1 \(\sum \text{Yes}	osy findings available apletion of cause of
ita	sian: ertifica ctor.	Bec	25. Was case referred to medical examiner?						of Death (iving Fac.
Division of Vital	To the Hospital or Attanding Physician: The within 24 hours effer death. To the Funeral Director: Affer this certificate his completely filled in by the funeral director; page	2	1 Pes 2 No 27. Manner of Death 132 Matural 5 Pending	ospital: 1 Inpatie 28a. Date of Injur (Month, Day			Bc. Injury Work	4 🗀 (Nul)	28	e 5 Reside)
Division	To the Hospital or Attant within 24 hours efter death To the Funeral Director: completely filled in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	iry - At home, farm . (Specify)					If. Location (Str City or Town		umber or Rural	Route Number,
	Hospital or 24 hours efte Funeral Dir etely filled in I	edical C	29a Cartifier Check outy one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examination and/	daeth snowns.f or investigation,	at the tim in my op	a date and pinion, death	lane, a	d dus to the ca I at the time, da	uso(s) and ite and pla	I manner ac ets ce, and due to	ntod. the cause(s)
)	To the within 2 To the complet	Med	29b. Signature and title of certifier	allredo	why	nD 290		number 08118		29		gned (Month, E ch 17,	
		(8)	30. Name and address of person who con Dr. Stanley Watkin		oath (Item 23a) (T		٦ ٦،	nnanal	ic	Mareral and	.a	401	
700	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 0 2006	•	nr's Signature	ALE RODO	ı Al	птарот	LIS,	marytan	u 21	401	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 17, 2006 JOANNE BARBARA SCHMIDT MARCH 11:59A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 183 32 4896 66 SEPT.17,1939 PENNSYLVANIA Usual Residence of Decedent with the Maryland 8 how 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shovers Medical Examinant must be notified at 1 ☐ Yes 2 🔀 No Directo MARYLAND ANNE ARUNDEL HARWOOD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1502-B FLANDERS LANE 20776 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 CLERK TELEPHONE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be fill of Health and Mentat H Be EDWARD WIETHOLDER HELEN NICKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM A. SCHMIDT (HUSBAND) 1502-B FLANDERS LANE HARWOOD MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of P ant: if ita 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) LAKEMONT CEMETERY 03-20-06 DAVIDSONVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, in each line. Immediate Cause (Final **Physician** a disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed. Yes 21X No 1 Tes 1 Tyes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Natural Accident 5 Pending investigation death. 1 Yes 2 No completely filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 / Homicide within 24 hours after To the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) State Registrar

		1 - State Registrar 1. Decedent's Name (First, Middle, Las,	State of Maryla		artment of F rtificate of			leg. No.	6	1 0 6 7 2
Physicia /Medic Examin	al	Effie A. Trainum 4a. Facility Name (If not institution, give Bowie Health Cer	street and number)		4b. City, Town, o	r Location of De	March	Day		2:30p
Funeral Director		5. Social Security Number 227–28–6964 1 Usual Residence of Decedent	M 252 F	s. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		Year)	9. Birth	uplace (State or Foreig Intry)
r 28e-f ehow	rector	10a. State 10b. County Maryland Prince 0 10e. Street and Number		Bowie	10f. Zip Code			l 0g. Citizen of V	What Cou	10d. Inside City Limits 1 Yes 2 No
s 1 and 2 should be filed within 72 hours after death with the Maryland Itaneath and Mental Hygiene. Itaneath and Mental Hygiene. Itanea 27 Is marked other then "natural; or Itams 23a or 28e-f show other traumetic event, the Musical Examiner must be natified at	by Funeral Director	3800 Enfield Cl 11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🏲 No If Yes, Give Year or Dates:	U.S. 13.	207 Was Decedent of H If Yes, specify Cuba		(Specify Yes or No- erto Rican, etc.)		e - Amer ck, White	ican Indian, , etc. White
e filed within 72 hours aft Il Hygiene. other then "naturel", or vent, It'e Modical Experi	Completed	15. Decedent's Edit (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of v i) ice Rep		16b. Kind of B		ndustry
id 2 should be file th and Mental Hy 27 Is markad oth traumetic evant	To Be	Benjamin A. Armst 19a. Informant's Name/Relationship (7) Lawrence Trainum/S	rpe, Print)	19b. Maili	ng Address (Street	Cora and Number or	A. Whist: Rural Route Number Rd., Oden	Leman	State, Zi	p Code)
rmit. Pages 1 and 2 partment of Health portent: If itam 27 I y injury or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 6 4 Donation 5 Other (Specify)	20b. Removal from State	Place of Dispo	esition (Name of matory or other place) 1n Crema	28)	Date	20c. Location -	City or T	
permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or comp	mule				eral Home Road, Br		, MD	20722 Approximate
/Medical Examiner physician and physician and physician and the prival transit	Ilcal Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	equence of):	ary Fibro	osis				Onset and Death 6 months
death certifii e attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2★ No 9 □ Unknown	33c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Da Mo	e of deliv	rery Day Year
es the igner	ρχ	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause give	en in Part I.				the cause of death? bably 4 🛣 Inknow
	Completed	OF Was and referred to profine						ry ned? 2.★No	prior to co death?	opsy findings available ompletion of cause of
£ 5 =	atlon; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	dospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injury Work	er: 4 ☐ Nursing	eath (Check only on Home 5 Reside 28d. Describe ho	ence 6 Oth		fy)
P S S	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			28f. Location (SI City or Town	n, State)		
To the Hospital or within 24 hours after To the Funarel Dir completely filled in	Medical	29a. Certifier (Check only onle) 2 ☐ Medical Exami 29b. Signature and title of certifier 30. Name and address of person who co	sician: To the best of my kr ner: On the basis of examinand manner stated.	nation and/or in	29c. License D365	oinion, death oc number	curred at the time, d	ause(s) and ma ate and place, a 9d. Date signed	and due t	Day, Year)
Stat Registra	-	S. J. Rao, M.D., 4 31. Date filed (Month, Day, Year) MAR 2.2 2006		ville F	Road, #220	O, Bowi	e, MD 207	716		

			1 - For State Registrar	State of Maryl			of Health a of Death		Re	<u> </u>	10673
	Physici		1. Decedent's Name <i>(First, Middle, Last</i> Mary Joan White	")					Date of Death Month arch 1	8, 2006 Year	3. Time of Death 6:10 P M
	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, T	own, or Location of			4c. County of Death	
1		36	Genesis College Vi				ederick			Frederi	ck
₩ #	Funeral Director		5. Social Security Number 6. Se 431-46-7578 Usual Residence of Decedent		yrs. last birthday 82 Yrs.		Year If Under Days Hours	Min. N	Date of Birth (Month, Day, OV • 14	, 1923 Ark	place (State or Foreign intry) ansas
	Maryland	tor	10a. State 10b. County Maryland Frederi		City, Town or L						10d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28	Funeral Director	10e. Street and Number 700 Toll House Ave			10f. Zip 0	21701		10	Og. Citizen of What Cou United Sta	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any injury or other treumatic event, I'm Medical Exacting cast for rotified at angle.	by	11. Marital Status 1∰Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	12. Was Decedent Ever Amed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates:	n U.S. 13	. Was Decede If Yes, specif	ent of Hispanic Ori fy Cuban, Mexican No Specify:	gin? (Specify i, Puerto Rica	Yes or No- an, etc.)	14. Race - Amer Black, White Specify: Wh:	, etc.
21215-0036	vithin 72 ho ne. han "natur	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Giv life.	DO NOT use	done during most retired)	t of working	1	16b. Kind of Business/I	ndustry
22	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	3	Nur	se Anes	sthetist	r's Namo /Fi	iret Middle N	Medical Maiden Sumame)	
Maryland	should be ind Mental I	To Be	Guerrald White				Agnes	s Johan	nna Up	tmoor	
	and 2 shealth and m 27 is n		19a. Informant's Name/Relationship (T) Patricia Cahaney /	Niece	8212	Winter	r Snow Ct	. Fred	derick	City or Town, State, Z., MD 21702	ip Code)
Baltimore,	Pages 1 nent of Hi ant: If ites ary or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Torrioral Horri Otato	b. Place of Disp cemetery, cre lesthave		1	arch 2	20,	oc. Location - City or Trederick.	
Balti	permit. Departn importe any injt		21. Signature of Ineral Surve Library		R	22. Name and esthave	Address of Facility en Funera	ĭ1 Serv	vices,	Skkot Cody derick, MD	7 P.A.
	8		23a. Pañ I. Enter the disease, or compl shock, or heart failure. List only o	lications that caused the c ne cause on each line.							Approximate Interval Between Onset and Death
	Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter unuerlying Cause (Disease or injury	a. Stroke Due to (or as a con ASCVD Due to (or as a con	sequence of):						
68760,	tificate be executed g physicien and as the burial-transit	ledical Ey	L.	Due to (or as a con	sequence or):						
P.O. Box	law requires that the death certificate be executed as been signed by the ettending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□Ectopic prec □ Other (spec				23d. Date of deliv Month	rery Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not	resulting in the	underlying cau	use given in Part I.			acco use contribute to	
<u> </u>	The ate h page	Completed							24a. Was an autopsy perform	ed? prior to or death?	opsy findings available ompletion of cause of
Vita Vita	cien:	Be	25. Was case referred to medical examiner?	1				of Death (Ch	heck only one),	
ot	Physic this c	2	1 163 2 X 140	Hospital: 1 ☐ Inpatient 2						nce 6 ☐ Other (Speci	fy)
sion	Attending Physicien: r death. ector: After this certification the funeral director.	Certification:	27. Manner of Death 1 ☆Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Year	28b. Time (r) Injury	M 280	c. Injury at Work? 1 ☐ Yes 2 ☐ N		Describe how	w injury occurred	
<u>N</u>	Dirte		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, si ecify)	treet, factory, o	office	28f. l	Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	To the Hospitai within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1⊠ Certifying Physical Check only 2 Medical Examinate one)	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, dea iination and/or ii	th occurred at nvestigation, in	the time, date and my opinion, deat	d place, and o h occurred at	due to the cau t the time, dat	use(s) and manner as t te and place, and due t	stated. o the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of certifier	- MA			License number 0060147			d. Date signed <i>(Month</i> , larch 19, 2	
	5		30. Name and address of person who co Hemen Shah, M.D.	ompleted cause of death (, Print)		lr M⊓	21702		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 2 2	00 0 0				, 111 <i>j</i>			

	1	For Stata Registrar	State of Ma	arylan		artment of I		nd Mer		jiene eg. No.	16	10674
Physicia /Medic		1. Decedent's Name (First, Middle, L CHARLES OBER	111.	R					Date of Dear Month	Day	Year 2006	3. Time of Death
Examin	er	4a. Facility Name (If not institution, great CARROLL HOSP17 5. Social Security Number 6.	AL CENTE		last birthday	4b. City, Town, o WESTMI) If Under 1 Year	NSTER	Death	Date of Birth	CAR	ROLL	
Director		220-05-2965 Usual Residence of Decedent	1 X M 2□F	89	Yrs.	Months Days	Hours		(Month, Day, 17–18-	, Year) -1916		yland
laryiand show	7	10a. State 10b. County MD Carro	11		y. Town or L					<u> </u>		10d. Inside City Limits
with the M s or 28e-f	Director	10e. Street and Number 1380 North M				10f. Zip Code	21074		1	0g. Citizen o		1 ☐ Yes 2 ☐ No ntry?
72 hours after death with the Maryland natural", or Items 23c or 28e-f show diest Examitrer shall be recitified at	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent & Armed Forces? 1 Yes 2 X	Ever in U	.S. 13.	Was Decedent of I	21074 Hispanic Originan, Mexican, Specify:		Yes or No- an, etc.)		USA ace - Ameri lack, White,	etc.
	Completed b	3 Widowed 4 Divorced 15. Decedent's I (Specify only highest g	Year or Dates: Education rade completed) College (1-4or 5	+)	(Give	edent's Usual Occu e kind of work done DO NOT use retire	during most (d)	of working		16b. Kind of	Business/In	•
tiled within Hygiene. other than ent, the Mu	Be Cor	17. Father's Name (First, Middle, Las	it)		Tr	cuck Dri		's Name (Fi		Fuel Maiden Suma		any
should be and Mental marked c	ToB	Oden B.	Walter					ry	В.	Wirt		
and 2 sh ealth and n 27 Is m		19a. Informant's Name/Relationship Patricia Hain		er		N. Gors						
permit. Pages 1 and 2 should be tiled within permit. Pages 1 and 2 should be tiled within Inportent: If item 27 is marked other than any injury or other treumetic event. If a Mode.		20a. Method of Disposition 1 Description Signature 1		20ь. Р	lace of Disp	osition (Name of amatory or other place ad Cem	ce)	Date 3 - 24		20c. Location	n - City or To	own, State
permit. Departr Importe any inj		21. Signature) of Funeral Service Lice	1	1005		22. Name and Address		D-T-T	ne Fu	neral	Hom	e 21074
Physician /Medical Examiner		23a. Part1. Enter the isease, or conshock, or heart failure. List onlimmediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	nolications that coused	the death ne. TITI a conseq	A L uence of):	PNEUMON:	ng, such as co	ardiac or re	spiratory arro	est,	rib	Approximate Interval Between Onset and Death
ate be hysicia the bur	ledicai Examlner	cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	c. ANEM1 Due to (or as d. DEMEN	a conseq								
that the death certific that by the attending p detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I déath 3	□Ectopic pregnanc □ Other (specify) _	у			1	Date of deliver	ery Day Year
quires that n signed b uld be deta	by P	Part II. Other significant conditions	contributing to death bi	ut not res	ulting in the I	underlying cause gr	ven in Part I.			bacco use co es 2□No		he cause of death?
The law requirate has been spage 2 should	Completed								24a. Was a autops perform	sy		opsy findings available impletion of cause of 2 No
sicien: certitic	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	20	FD/0	Ott	200		heck only on			
	\vdash	27. Manner of Death 1 Natural 2 Accident 5 Pending investigati	28a. Date of Injui (Month, Day	v	28b. Time of Injury	of 28c. Inju	ry at	28d.		ence 6 🗆 O		у)
tel or Atters atter des	Certification:	3 Suicide 6 Could not determine		ury - At he	ome, farm, si	treet, factory, office		28f.	Location (St City or Town	treet and Nun n, State)	nber or Rura	al Route Number,
the Hospi in 24 hour the Funer pletely till	Medical		hysicien: To the best of iminer: On the basis of and manner sta	examina								
To t To t	Σ	29b. Signature and title of certifier				29c. Licens	se number			9d. Date sign		
المحتبارة		39. Name and address of person who	o completed cause of de			, Print)	E, MD	2 ^ 7		- 121	,	
Sta Registra		31. Date filed (Month, Day, Year) MAR 2 2 2	32 Applicates	ar's Signa			6/11/12	201	17			

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of rtificate of		d Mental Hy	giene	0675			
i	Physici		1. Decedent's Name (First, Middle, Last) Charles Phillip					2. Date of De Month March	-	3. Time of Death 12:45 p M			
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of D		4c. County of [
			Shady Grove Adventist			Rockv				gomery			
	 Funeral Director 		5. Social Security Number 6. Sec. 18-03-3157	7. Age	(In yrs. last birthday) Yrs.	If Under 1 Yea Months Days		Hrs. 8: Date of Bir Vin. (Month, Da April 4	orth ay, Year) 1912 V	Birthplace (State or Foreign Country) irginia			
	e Maryland Ba-f ehow	ctor	10a. State 10b. County Maryland Montg		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🔀 No			
	th with the	Funeral Director	9701 Medical Cent	er Drive		10f. Zip Code 2085	50		10g. Citizen of Wha				
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or iteme 23e or 28e-f show other traumatic event, the Medical Exercities must be inclined at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu		? (Specify Yes or No uerto Rican, etc.)	14. Race - A Black, V Specify:	American Indian, Vhite, etc. White			
21215-0036	within 72 ho lene. than "natu he Medicel	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retir	a during most of	working	16b. Kind of Busine	ess/Industry			
	e filed w Il Hygier other th		12 17. Father's Name (First, Middle, Last)		Rea	1 Estate				Estate			
Maryland	2 should be to and Mental Nis marked of raumatic even	To Be	Horace Wood				Viola	Name (First, Middle Phillips					
Mar	d 2 sh th and th and ?7 is m traum	1 3	19a. Informant's Name/Relationship (Ty) Susan Wood Erick						er, City or Town, Star McLean, Vi				
Baltimore,	ges 1 and 2 of Health if item 27 or other tra		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R		20b. Place of Dispo		acal	Date rch 21,	20c. Location - City				
買出	permit. Pages Department of H Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Signattre of Funeral Service License		Metropolit		ry	2006		a, Virginia			
Ba	Depril		1 Jans 50) coley	5	00 Unive	rsity B	lvd, W, S		ing, MD 20901			
	Physician		23a. Part1. Inter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition	ne cause on each line.	ne death. Do not ent · ·lar Tachy		ing, such as car	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death			
	/Medical Examiner		resulting in death)		consequence of):								
	ted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	to (or as a sursequence of): Dertension								
8760,	sate be executed physicien and the burial-transit		that initiated events cresulting in death) Last	Due to (or as a consequence of): Dementia									
687	ificate physics the	edica		. Demerrera									
P.O. Box	The law requires that the death certificate be executed to hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pregnand Other (specify)	cy		23d. Date of Month	delivery Day Year			
	ires that the de signed by the a d be detached f	þ	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause g	ven in Part I.			use contribute to the cause of death?			
Vital Records,	aw require	Completed	24a. Was an 24b. Wer							autopsy findings available			
a R								1 ☐ Yes	rmed? death	to completion of cause of 1? 'es 2 No			
=	Physician: r this certifica ral director, j	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	2 ER/Outpatien	t 3 DOA O		Death Check only o	on <i>e)</i> dence 6 □Other (5				
n O	ng Pl	T:UO	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)					now injury occurred	респуј			
Division of	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	r - At home, farm, str		Yes 2 □No	28f. Location (5	28f. Location (Street and Number or Rural Route Number.				
	pital or urs afte sral Dir		4 Homolog	building, etc.				City or Tov					
	ns Hos	edical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☐ Medical Examin	sician: To the best of or ner: On the basis of ex and manner state	xamınatıon and/or ını	occurred at the trestigation, in my	ime, date and pla opinion, death o	ace, and due to the courred at the time,	cause(s) and manner date and place, and c	as stated. due to the cause(s)			
	within To th	Ž	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Me	onth, Day, Year)			
,	3		30. Name and address of person who cor	Mully M	th (Item 22a) (Tue-		34120	00	3-71-01	0			
			Anushiravan Dado	gar, M.D.	9715 Med		ter Driv	ve, #201,	Rockville	, MD 20850			
1000	Sta Registra		31. Date filed (Month, Day, Year)	32 Registrar's	s Signature	Wed .							

		1 - For State Registrar	State of Ma			of Health and I of Death		giệne _{Reg. No.}	JUb	100/0
		1. Decedent's Name (First, Middle, La	st)	·			2. Date of Dea	ıth		3. Time of Death
Physic /Med		Edith Leep	er 1	Weinberg			March	21^{ay}	2006	10:30A. M
Exam		4a. Facility Name (If not institution, given 11410 Strand Driv				wn, or Location of Death	h	4c. County of Death Montgomery		
Funera		Social Security Number 6. S	ex 7. Age	(In yrs. last birthday			8. Date of Birth	1 .		
Directo			□M 2 X F	79 Yrs.	Months D	ays Hours Min.	8. Date of Birth (Month, Day Feb. 3,	1927	Akro	place (State or Foreign on, Ohio
pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	cention					10d. Inside City Limits
eho	2	Maryland Montgom		Rockvi						1 Tyes 2 No
the N	ect	10e. Street and Number	ier y	NOCKVI		do		IOn Citi		
ith with 23a or	al DIr	11410 Strand Driv	re, #314		10f. Zip Co	20852			nited St	
ING Z1Z13-UU35 be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or Items 23a or 28a-f ehow event, the Medical Evanirar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Education Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:	ver in U.S. 13	. Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puert No Specify:	pecify Yes or No- o Rican, etc.)	1	14. Race - Ameri Black, White Specify:	
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. Dec	edent's Usual O	ecupation	dela a	16b. Kir	nd of Business/Ir	ndustry
L L L	nple	Elementary/Secondary (0-12)	College (1-4or 5+	}		lone during most of wor etired)	King		_	
ed w	Co			Doce	nt			U.S	. State	Departmen
0 = 0 >	e	17. Father's Name (First, Middle, Last) William		Lee	per	18. Mother's Nan Alice	me (First, Middle, i	Maiden .	Sumame)	Sloan
Mary Mary Mary Mary Mary Mary Mary Mary		19a. Informant's Name/Relationship (Barry J. Weinberg	Type, Print) SON	19b. Mai 520	ling Address (Si North a	reet and Number or Ru nd South Ro	oral Route Number	r, City or Uni	Town, State, Zi, Versity	City,MO63
Baltimore, Marylar permit Pages 1 and 2 should b Department of Health and Ments important: If them 27 is marked any injury or other traumatic e		20a. Method of Disposition 1\(\sum_{\text{D}}\) Burial 2 \(\sum_{\text{Cremation}}\) Cremation 3 \(\sum_{\text{D}}\) 4 \(\sum_{\text{D}}\) Onation 5 \(\sum_{\text{D}}\) Other (Specify 21. Signature of Faperal Service Licer	Man	D 2	id Mem. onald V 400 Pow	Gardens 3/ ddress of Facility Borgwardt der Mill Ro	/24/2006 t Funeral pad Belts	Fal L Hor		ch,Virginia
Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, are heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Metasta	he death. Do not end. atic Brea consequence of):	nter the mode of	dying, such as cardiac	or respiratory arm	est,		Approximate Interval Between Onset and Death 1 year
ecuted and -transit	I Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):								<u> </u>
ficate be ex physician to the burial	edical		d							
The Colds, F.O. BOX of The law requires that the death certificate has been signed by the attending page 2 should be detached for use as in	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							3d. Date of deliv Month	ery Day Year
w requires that the dibean signed by the should be detached	b b	Part II. Other significant conditions of	1 / 1						Use contribute to the cause of death? 2 □ No 3 □ Probably 4 ※Unknown	
The law requals has been page 2 shou	ompleted	24a. Wa aut						y	24b. Were autopsy findings available prior to completion of cause of death?	
VICIAN: The vician: The certificate rector, pag	O						perform 1 Yes 2	2X No	1 Yes	2□ No
viciar viciar certif	Be	25. Was case referred to medical examiner?	Hospital:			011	th Check only on			
Phys Phys	P.	1 ☐ Yes 2 No 27. Manner of Death	1 L Inpatient	2 ER/Outpatie			ome 5 Reside			۶)
- 6 9 9	atlon	1 Naturat 5 Pending 2 Accident investigation		Year) 28b. Time Injury	M 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	zaa. Describe ho	ow injury occurred		
Hospital or Attending Hours after death. Funeral Director: After	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury building, etc.	/ - At home, farm, s (Specify)	treet, factory, of	ice	281. Location (St. City or Town	reet and n. State)	Number or Rura	al Route Number,
To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fue	edical C	29a. Certifier 12 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of e and manner state	xamination and/or ii	th occurred at the	ne time, date and place, my opinion, death occur	, and due to the ca rred at the time, da	ause(s) a ate and	and manner as s place, and due to	stated. the cause(s)
To the withing to the comp	Me	29b. Signature and title of certifier	12/		29c. Lie	ense number	2!	9d. Date	signed (Month,	Day, Year)

State Registrar 31. Date filed (Month, Day, Year) MAR 2 2 2006



D22775

March 21, 2006

20

			1 - For Stata Registrar	State of Man		artment of H			giene Rag. No.	106	10677
	Dhysiai		1. Decedent's Name (First, Middle, Last	•				2. Date of De	6 A 147	Year	3. Time of Deathp
	Physici /Medi		William	Harvey	Wrote	n Jr.		March		006	2:20 M
4	Examir	er	4a. Facility Name (If not institution, give	·		4b. City, Town, or		th		unty of Death	
	Francis		William Hill Man 5. Social Security Number 6. Se		n yrs. last birthday)	Easton If Under 1 Year	If Under 24 Hrs	8. Date of Birt		albot	lace (State or Foreign
L	Funeral Director			XIM 2□F 86		Months Days	Hours Min.	(Month, Da) 1/6/19	y, Year)	Coun	yland
	yland 10W		10a. State 10b. County	10	Oc. City, Town or Lo	ocation				16	0d. Inside City Limits
	a-fsh	tor	Maryland Talbot		Easto	n				İ	1 XYes 2 □ No
	within 72 hours after death with the Maryland jiene. rithan "natural", or Itams 23a or 28a-f show Ite Madical Examitrational by radified at	i Director	10e. Street and Number 501 Dutchmans Lan	e, Apt. 320)	10f. Zip Code 216Q	1		10g. Citízen USA	of What Coun	try?
	death	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		Was Decedent of Hi	spanic Origin? (S	Specify Yes or No-	14.	Race - America	
36	urs after al', or Ita	by Fu	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 TaYes 2 TNo		lf Yes, sp <i>ec</i> ify Cubai 1 ☐ Yes 2 ☑ No	Specify:	to Rican, etc.)		Black, White, e ecify: Wh	ite
Maryland 21215-0036	72 hou	ted	15. Decedent's Edu	ucation		dent's Usual Occupa		dein-	16b. Kind	of Business/Ind	lustry
21	within 7 ene. than "r	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done d DO NOT use retired,))	rking			
2	e filed within Il Hygiene. other than vent, Ille M.	Co	12	4⊹	Edu	cator	40 14-15 1 11			ation	
anc	0 0 0 0	Be	17. Father's Name (First, Middle, Last)	heat on Cie				me (First, Middle,	Maiden Sui	name)	
Ž	2 should be and Ment Is marked eumatic e	2	William Harvey W		19b. Mailir	ng Address (Street a		Conway ural Route Numbe	r. City or To	wn State Zin	Code)
\mathbf{z}	2 # Z		Thomas W. Wroten/			09 Johnso					
J.	ges 1 a t of Hea If item or othe		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place	g)	Date	20c. Locati	on - City or To	wn, State
Ē	Pages ment of ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)			y Cremato	· 1 .	20/06	Sali	sbury,	MD
Baltimore	permit, Pag Department Important: I any injury o		21. Signature of Funeral Service Licent	Perney C	FSP H	Name and Address Olloway F Ol Snow H	uneral H	Home Prof Salisbu	ession	nal Ass D 21804	sociation
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the							Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	a /<	PATES	atom P	ailure			1	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):		Cilm	1			Ym
		E.	if any, leading to immediate	b. Due to (or as a cr	CU/MO	Mas	LOUGE .	w	-		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	. (" Kam	4 0 (v)	truck	ue him	, De	10al	for
ó	exec an an rial-tr		resulting in death) Last	Due to (or as a co	onsequence of):			7 330	7		
8760,	cate be executed bhysician and the burial-transit	dicai		d							-
9	certific anding p	/Mec	IF FEMALE:	200 16							
Box	death e atte	Physician/Me	in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d.	Date of deliver Month	ry Day Year
P.0.	that the de led by the a detached t	Phy	9 Unknown								
Vital Records,	ed bed	by	Part II. Other significant conditions co	tributing to death but n	ot resulting in the u	Harrying cause give	n in Part I.	239. Did to	_		e cause of death?
000	aw requit is been s 2 should	Completed	Didbettes Melli	bus.				24a. Was a	an 24	b. Were autop	sy findings available apletion of cause of
Ä	The lav	Com	Mus Por Nessa	Pana				autop perfor 1 ☐ Yes	med? 2 12 No	death?	
/ita	ysician: Th is certificate director, pag	Be (25. Was cade referred to medical examiner?				26. Place of Dea	ath (Check only or			
	hys this al dir	2	1 ☐ Yes 2 ☐ M6	Hospital: 1 ☐ Inpatient	2 ER/Outpatien		4 A Nursing H	lome 5 Resid)
n	ding f h. After funer	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	Work	at ? ′es 2 ⊟No	28d. Describe h	ow injury oc	curred	
Division of	or Attanding ifter death. Diractor: After in by the funer	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, str Specify)		03 2 10	28f. Location (S City or Tow	treet and Nu n, State)	ımber or Rural	Route Number,
	To the Hospitel or Attanding Rewithin 24 hours after death. To the Funaral Director: After completely filled in by the funer.	edical Ce	29a. Certifier 12 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of m	amination and/or in	n occurred at the time vestigation, in my op	e, date and place inion, death occu	o, and due to the d arred at the time, d	ause(s) and late and plac	manner as sta	ited. the cause(s)
	ithin 2	Med	29b. Signature and title of certifier	and manner stated		29c. License				gned (Month, D	
	F ≥ F SA		1/100,000	46 12 D N			8719		2	72/x	3
	2000		30. Name and address of person who co	ompleted cause of death	n (Item 23a) (Type.	0	0 /1 /		-1	270	€
	12%		William H. Wood.			ns Lane, l	Easton,	MD 21 601			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature						

DHMH 17 Rev 1/2001

ORIGINAL

		4	For State 0	f Maryland /		rtment of He			6000	10678
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	incate of D	Calli	2. Date of Death	g. No.	3. Time of Death
ı	Physicia /Medic		Allen Herman Wilds					Month	Day Yeer	17:50 PM
	Examin		4a. Facility Name (If not institution, give street and num			4b. City, Town, or L			4c. County of Dea	th
				(Courty		El K-too	If Under 24 Hrs.	8. Date of Birth		thplace (State or Foreign
П	Funeral		5. Social Security Number 6. Sex 1 № M 2 ☐ F	7. Age (In yrs. last L	Yrs.	Months Days	Hours Min.	(Month, Day,	6, 1920 Ke	ountry)
	Director		222-09-8315 Usual Residence of Decedent	85				April	0, 1920 NE	
	ylend		10a. State 10b. County	10c. City, To						10d. Inside City Limits
	Mar B-f st	tor	Delaware New Castle	Mid	ldlet	own				1 Tes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code 19709		10	0g. Citizen of What C	ountry?
	23a	rai	11 West Redding Street		1			ait. Van ar Na	14. Race - Am	erican Indian
	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show the Medical Examinan mast be motified at	Funerai	Amed Fo		13.	Was Decedent of His If Yes, specify Cuban	, Mexican, Puerto	Rican, etc.)	Black, Whi	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes If Yes, Gi 3 ☐ Widowed 4 ☐ Divorced Year or D	ve ates: WWII		1□Yes 2√√No	Specify:		Specify:	White
Ö	2 hou	ted	15. Decedent's Education		6a. Dece	dent's Usual Occupet kind of work done du	tion	na	16b. Kind of Business Retail	/Industry
215	hin 72	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use retired)				
2	giene grene er the	E C	12		usto	mer Servi			Food Mar	Ket
nd	al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name Helen		valden Sumame)	
y la	Mend Mend Mend Mend Mend Mend Mend Mend	ဥ	J. Herman Wilds		Ob Mailie	an Address (Street as			, City or Town, State,	Zin Code)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel; or items 23a or 28a-1 show amy injury or other treumatic event. It a Medical Examinat nast be notified at Once.		19a. Informant's Name/Relationship (Type, Print) John Wilds-Brother		21	Boxelder	Lane,	Bear,	DE. 1970	1
e,	1 and Healt em 2		20a. Method of Disposition	20b. Place	of Dispo	sition (Name of			20c. Location - City o	r Town, State
altimore,	ages int of t: if it		Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	etery, crei	matory or other place Cemete ans Memori	ry	h 27, 20	no Bear	, DE.
Ħ	artme orten injuri		21 Signature of Funeral Service Licensee	DE: VE	22	Name and Address	s of Facility			
B	permi Depar impo any ir		John Dungy	and h	Da	niels & H	lutchison	Funeral	Homes, 2	12 N. Broad
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death.	Do not en	refrire mode of dying	such as cardiae	or respiratory arr	est, 5	Approximate Interval Between
	Pnysician	77 3			Designed L	igity scyl	swed Pl	revuen	(=1	Onset and Death
	/Medical			(or as a consequen		()				/ -
	Examiner		Sequentially list conditions, b.							
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequent	ce out:					1
	be executed icien and burial-transit	Examin	that initiated events c.	(or as a consequen	ce of):					
760,	ate be executed nysicien and he burial-transit	calE								
687	ificate g phys as the									
Box	The law requires that the death certificate the has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant	itcome of pregnancy birth 2 Petal de		☐Ectopic pregnancy			23d. Date of d Month	elivery Day Year
	death	sicia	in the past 12 months? 1 Yes 2 No 4 Preg	nant at time of death		Other (specify)			141011111	Day Four
P.0	that the de led by the a detached f	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to	tooth but not resultin	ag in the I	inderlying cause give	n in Part I	23e. Did to	bacco use contribute	to the cause of death?
	ires tha signed d be del	by	Pan il other significant conditions continuous to	- Fe - 7.	7C	anderlying cadde give	ar iir are v	1 □ Y		Probably 4 Unknown
orc	w requir been si should	eted	Classical	AA:				24a. Was a	24h Were	autopsy findings available
Records,	e law has t	Completed	Chronic Plual 1450	TITLIEUC	7-			autops perfor	sy prior to med? death	completion of cause of
alF			OF War area referred to modical				26. Place of Deal		7	es 2 No
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER	VOutpatie	int 3 DOA Othe	ar-	-100	ence 6 □Other (Sp	pecify)
of		-			Bb. Time of				ow injury occurred	
ion	Attending F ir death. ector: After by the funer	atio	1 Natural 5 Pending (700 2 Accident investigation	nin, Day rear,	mjury		Yes 2 □ No			
Division	i or Attendi after death. Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buil	e of Injury - At home	e, farm, s	treet, factory, office		28f. Location (S City or Tow	itreet and Number or . n, State)	Rural Route Number,
٥	tel or A rs after el Dire ed in by	Cer								
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Physician: To the (Check only 2 Medical Examiner: On the	basis of examination	edge, dea n and/or i	th occurred at the tim nvestigation, in my op	ne, date and place, pinion, death occur	and due to the or red at the time, o	ause(s) and manner date and place, and d	as stated. ue to the cause(s)
	the	Med	29b. Signature and title of certifier	nner stated.		29c. License	number	2	29d. Date signed (Mo	nth, Day, Year)
	₽ ₹ ₽ 8					0000	5/90	l	Mardy 2	1.2006
11	5) (5)		30. Name and address of person who completed ca		3a) (Type	, Print)	, - 1 (0	10		1,2006
(1) States		Alfred A Piro Mo		2500	tal 106 8	Jow Stre	et Eli	Ktoy, M	159150
	Si	tatė	111111111111111111111111111111111111111	Registrar's Signature		- 8				
	Regis	trar	MAR 2 / 2006	P fear	M	Angelle)				
D	HMH 17 Rev 1/	2001	100 11 12 2 2000	Jan	DICIN	Al				
				0	RIGIN	ML				

State of Maryland / Department of Health and Mental Hygiene 005 105 10

			1 - State Registrar		Cei	tificate of i	Death		Reg. No.	000	10072
	11 4 1		1. Decedent's Name (First, Middle, La	st)				2. Date of De	_	Year	3. Time of Death
	Physici /Medic		Lemuel	Pau	1	Yokum		03	1 Coay	00	0106
		Examiner 4a. Facility Name (If not institution, give street and num			1	4b. City, Town, or	Location of Death		4c,	County of Dea	th
			STURED HE	ART HOSD	TAL	Com	berlan	JD	1	7116dc	ny
-	Funeral		5. Social Security Number 6. S		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Bir (Month, Da	th Vaar	9. Bir	thplace (State or Foreign
	Director		214-28-6203	™ 2□F 83	Yrs.	Months Days	Hours Min.	07/23/	1922	Per	nnsylvania
	D.		Usual Residence of Decedent				-				
	how		10a. State 10b. County	10c. 6	City, Town or Lo	cation					10d. Inside City Limits
	B-f-	cto	PA Bedfo	rd	Cle	arville					1 ☐ Yes 2 ☐ No
	death with the Maryland rne 23a or 28a-f ehow r nest be notified at	Director	10e. Street and Number		_	10f. Zip Code			10g. Cit	izen of What C	ountry?
	1h wi		749 S. Bla	ck Valley Roa	ıd	15.	535			USA	
	dea	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No	D-	14. Race - Ame Black, Whi	
٥	or Ite		1 Never Married 2 Married	1 ☐ Yes 2 ☒ No		1 ☐ Yes 21∑ No		rindari, Oto.,			te, etc.
3	ours	1 by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		TO TOS ZANO	opecity.			Specify:	White
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene if Health and Mental Hygiene was selected of the than "nature!; or Iteme 23a or 28a-1 show other traumatic event, the Medical Examinar mant be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ducation		dent's Usuaf Occup	ation during most of work	ina	16b. K	ind of Business	/Industry
N	within 72 ene. than "nai	pldu	Elementary/Secondary (0-12)	Colfege (1-4or 5+)	life. I	DO NOT use retired	d)	3			
N	or th	Sol	12		We	lder				Jtility	
and	al Hy	Be (17. Father's Name (First, Middle, Last,				18. Mother's Name	e (First, Middle	, Maiden	Sumame)	
<u>a</u>	2 should be filed w and Mental Hygie ie marked other treumatic event, II.	To	John	William	Yo	kum	Lettie		Ret	ecca	Judy
a	and l		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street	and Number or Rura	al Route Numb	er, City o	r Town, State,	Zip Code)
Z	alth alth 27 i		Richard D. Yokum	/ brother	3331	Chanevs	ville Roa	d. Clea	rvi1	le. PA	15535
<u>5</u>	of He item		20a. Method of Disposition		. Place of Dispo	sition (Name of natory or other place		Date	20c. Lo	ocation - City or	Town, State
Ē	Page ent c nt: If ry or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			Cemetery	1	1/2006	C1	earvill	o DA
aitimor	permit. Pages in Department of Himportent: If ite eny injury or ot once.		21. Signature of Funeral Service Licer		22	. Name and Addre	ss of Facility Ad	ams Fam	ilv	Funeral	Home, P.A.
ñ	Depariment Department of the partment of the p		12 + 6 /	Coleman !			r Street,				
			23a. Part1. Enter the disease, or com	plications that caused the de			·			<u></u>	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	Λ	0 1					Interval Between Onset and Death
	Physician		disease or condition resulting in death)	a acute R	enal	tailure	-				oneday
	/Medical Examiner		1	Due to (or as a cons	equence of):	i 1	a bleed	A" > 4 O			, ,
			Sequentially list conditions,	b. acute G Due to (or as a cons	astroir	ireshna	x bleeco	1 ng			one day
	sit s	lue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equerice oi):						
	ecute and -tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	aguanca of):						
ຊົ	Sien Sien Surial			Due to tor as a cons	equence on.						
09/80	eath certificate be executed ettending physicien and for use as the burial-transit	Medical		d							
٥	entific ling F e as	Me	IF FEMALE:								
ô	ath c ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	etal death 3L	Ectopic pregnancy	,			23d. Date of de Month	fivery Day Year
	e deg	Sic	1 Yes 2 No	4 Pregnant at time of 9 Unknown	fdeath 5□	Other (specify)				11101111	<i>Du</i>)
Į.	at the	by Physici						00 011			
ń	gnec bed	þ	Part II. Other significant conditions of			nderlying cause giv	en in Part I.				o the cause of death?
ב	w requires that the death c been signed by the ettenc should be detached for us	Completed	Advanced	Dement				10	Yes 2	□No 3□P	robably 4 Unknown
Records,	lawr es be	ple						24a. Was		24b. Were a	utopsy findings available completion of cause of
	The I	E							ormed? 2 X No	death?	2 2 No
VITAI	ucien: The lav certificete hes rector, page 2	a	25. Was case referred to medical				26. Place of Deatl				
	Physicien: this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ② No	Hospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth				6 □Other (Spe	ecify)
0	g Ph er th eral	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. fnjur Wor		28d. Describe			
0	ndin Ith. P fun e fun	atlo	1 Natural 5 Pending 2 Accident investigation		Injury		Yes 2 □ No				
UNISION	Attending is a death.	‡ C	3 ☐ Suicide 6 ☐ Could not b	288. Place of injury - At	home, farm, str	eet, factory, office					ural Route Number,
5	afte Dir d in t	Certification:	4 Homicide	building, etc. (Spe	city)			City or To	wn, State	3)	
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Pt	nysician: To the best of my k	nowledge, death	occurred at the tin	ne, date and place,	and due to the	cause(s) and manner a	s stated.
	e Fu e Fu ietely	Medical	(Check only 2 Medical Exar	niner: On the basis of exami and manner stated.	nation and/or in	vestigation, in my o	pinion, death occurr	red at the time,	date and	d place, and du	e to the cause(s)
	Fo th withir Fo th	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Da	te signed (Mon	th, Day, Year)
)	A 1		> worrock&	hin MD		Doos	55325		Ma	ach. 16	, 2006
	(13) 2		30. Name and address of person who		em 23a) /Time						,
	pel		WONSOCK SHIN	MIN AS TOT	200 Ta	-0.55	mething c	MIN	216	3 >	
	Sta	to	31. Date fifed (Month_Dav_Year) —	32. Registrar's Sig	nature .	RICE IV	2310003		~()	10	
	Registr		31. Date fifed (Month, Day, Year)	completed cause of death (IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	15/	GOORES .					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 19, March 2006 12:25 AM JANE С. YOUNG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner National Lutheran Home, Montgomery 9701 Viers Dr. Rockville 8. Date of Birth (Month, Day, Year) September 8,1923 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Min Months Days Hours Michigan 1□M 2X F 82 Director 301-14-6221 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-1 show rel', or Items 23e or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Directo Virginia Fairfax 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. #1004 20190 11400 Washington Plaza West, death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🋣 No If Yes, Give 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White If Yes, Give Year or Dates: Completed by 3 Widowed 4 NDivorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic avant, If a Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Education Art Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi 2 Cecelia Matchett Herbert Morris White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl ment of Health and ant: If item 27 ia n Harry F. Young/Former Husband 11400 Washington Plaza West, Reston, VA. 20190 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 Cremation&Memorial Ctr 3/21/06 Chantilly, Virginia \4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityMurphy Falls Church Funeral Home 21. Signature of Funeral Service Licensee 1102 W. Broad St., Falls Church, Va. 22046 23a. Part 1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PARODITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit DEMENT ADVANCED the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 🗶 No Physicien: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 🛣 No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After I or Attanding 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident investigation Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D0051158 MARCH 19 2006 n.0 Mull 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD20850 ROCKVILLE VEIRS DRIVE 9701 7.0 AWTHONY 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

			State of W	aryland	-	tificate of		F	eg. No.	10681
			1. Decedent's Neme (First, Middle, Last)					2. Dete of Dee Month	th	3. Time of Death
	Physicia /Medic		DOROTHY	BOETT	ГСНЕ			April	04 20	06 7:00 AM
	Examin		4a Fecility Name (If not institution, give street end number)				4b. City, Town, or Lo Catonsv		4c. County of	imore
			St. Joseph's Nursing Home 5. Social Security Number 6. Sex 7. Ag	ge (In yrs. les	t hirthday)	If Under 1 Year	If Under 24 Hrs.			9. Birthplace (State or Foreign Country)
	Funeral Director		217-26-2524 1□M 2XF	76	- 1	Months Days	Hours Min.	8. Date of Birth (Month, Day NOV 18	, Year 1929	Maryland
	land	ŀ	10a. Stete 10b. County	10c. City, T	Town or Lo	cation				10d. Inside City Limits
	a-fah	햦	Maryland Baltimore		Cato	nsville				1 ☐ Yes 2/☐ No
	3s or 28	al Direc	10e. Street end Number 2006 Oak Lodge Road			10f. Zip Code 212	28		iog. Citizen of Wit US	
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours eftar death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 Wifeld From 1 Yes 2 Wifeld From 1 Yes, Give Year or Dates:	No	1	□Yes 2X No			Black	- American Indian, , White, etc. White
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)		16e. Deced (Give	ent's Usual Occup	pation during most of work d)	ing	16b. Kind of Bus	iness/Industry
121	And the sign of th	du	Elementary/Secondary (0-12) College (1-4or	5+)			d)		Medi	cal
2	Hygie ther t	8	12 17. Father's Neme (First, Middle, Last)		36	cretary	18. Mother's Nam	e (First, Middle,		
an	d be ental	o B	William Larkin				Hester	Ingram		
ary	shoul nd M	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Address (Street	and Number or Rui	el Route Numbe	r, City or Town, S	itate, Zip Code)
	and 2 atth a 27 is		Jean M. Cremen, Daughter							land 21228
Baltimore,	Peges 1 and of Heint of Heint If Item		20a. Method of Disposition 1♥ Buriel 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify)			sition (Neme of natory or other pla Memorial	ce) Park C	Date 04/06/06		city or Town, State
Balt	permit. Departmine imports any injuite.		21. Signature of Funeral Service Licensee Thomas Gregor		3	01 Frede	uneral Ho	l Catons	ville, M	Maryland 21228
			23a. Pert1. Enter the diseese, or complications that ceuse shock, or heart failure. List only one cause on each I	d the death.	Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician									1 6
1	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)				men's [EMED	1 117	14 YEARS
		Je.		Due to (or e	es a conseq	uence of):				1 0
	tificate be executed g physician end as the bunal-trensit	edical Examiner	Sequentially list conditions.	Due to (or e	es e conseq	uence of):		<u> </u>		
0	e exe	EX	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury c							
68760,	ate b	dica	that initiated events resulting in death) Last	Due to (or a	is e conseq	uence of):				
	ding p	Me.	d							
Вох	etten for us	clan					in Dod I	agh Did	obacco use con	tribute to the cause of death?
P.O.	that tha daath cer ed by the ettendir detached for use	by Physician/M	Part II. Other significent conditions contributing to death t	out not resulti	ing in the u	nderlying cause gr	ven in Pari I.	1 🗆		3 Probably 4 Unknown
	as that igned b	Y P							4	
Records,	Attending Physician: The lew requiras that tha daath certificate be executed in death. sctor: After this cartificate has been signed by the ettending physician end by the funeral director, pege 2 should be detached for use as the bunal-trensit	Completed t							an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
	he lev e has ege 2	E O						10	res 20 No	1 ☐ Yes 2 ☐ No
of Vital	an: T	Bec	25. Wes case referred to medical				26. Plece of Dee	th (Check only o	ne)	
>	nysici nis ca I direc	70	examiner? 1 Yes 2 No Hospital: 1 Inpat		R/Outpatier	1 3LI DOA			dence 6 □Othe	
פע	ng Pt ifter tt unera	Ë	27. Menner of Death Natural 5 ☐ Pending 28a. Dete of Inj (Month, De	ary By Year) 2	28b. Time o Injury	Wo	inyet ork?]Yes 2 □No	28d. Describe	now injury occurre	3d
Sio	death. ctor: A y the f	cati	2 Accident investigation 3 Suicide 6 Could not be 388 Place of Ir	niun, - At hor	ne farm str	eet, factory, office		28f. Location (Street and Numbe	er or Rural Route Number,
Division	or At after of Direction by	Certification:	determined 200. I lace of I	tc. (Specify)		oot, tactory, cinco		City or To		
	To the Hospital or Attending Physician: The lew requiring within 24 hours after death. To the Furneral Director: After this cartificate has been sit completely filled in by the funeral director, page 2 should	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best and Medical Examiner: On the basis on end manner send manne							
	othe vithin omple	N e	29b. Signature and title of cartifier			29c. Licen	se number		29d. Date signed	(Month, Day, Year)
	- 3 - 0		> X MAN M	.D.		Do	00400	12	APRIL	4, 2006
	1		30. Neme and eddress of person who completed cause of	death (Item 2	23e) (Type,	Print)	- Tre 20	V C.=	MISDILLI	e, mo 2122A
•	ال		Scott Poweron, 405 F	-rene	5 (CIC)	~ ICU, >	2111200	1/ 04	J 450. W	,
	Sta Registi		31. Date filed (Month, Day, Year) 32. Regist	trer's Signatu		est)				(Month, Day, Year) 4 (Month, Day, Year) 4 A 006 6, MO 21228

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 5 8 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>06</u> April **Physician** Lawrence George Bednar Sr. 4. 4:30 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 313 Wye Road Baltimore Essex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 15℃M 2□ F Months Days Hours 182 32 3607 65 Director Jan. 26, 1941 Pennsylvania Usual Residence of Decedent 10h County 10a State 10c. City. Town or Location 10d. Inside City Limits 28e-f ehow the Medical Examiner must be notified at Baltimore 1 Yes 2X No Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 靣 313 Wye Road 21221 USA Itеms 23a Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1958/61 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status hours after 1 ☐ Never Married 2 X Married Specify: White naturel', or 1 ☐ Yes 2 No Specify δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanic Steel Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked of eny injury or other traumetic even 8 George Bednar Antonette Suskevich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Bednar (Wife) 313 Wye Rd. Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/10/2006 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland re of Funeral Service jac 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. Þ 1407 Old Eastern Avenue Essex, Maryland 21221 23a (Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreake **Physician** 2 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that the death certificate be executed transit that initieted events resulting in death) Last Due to (or as a consequence of) **burial**physician Physician/Medical as the attending for use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) ☐Yes 2☐No the 9 Unknown Ś signed Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? requires 99 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 1 Yes 2 XNo director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 2 X10 Other: 2 1 🗌 Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After the Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide the Funerel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination, ind/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only within 24 29b. Signature and le of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar William

31. Date filed (Month,

Maryland 21215-0036

altimore,

Box 68760,

0

م

Records,

Vital

of

Division

DHMH 17 Rev 1/2001

ORIGINAL

2021 BEMMONTARD Switt 213 Bellie Md 21015

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Waterfield,

R 0 6

MD

3 Registrar's Signature

			i icasc	State of Ma						_			
			1 - For State Registrar	Otato or ivid	arytaria i			te of Deat			Reg. No.		10683
	#1 35 P		Decedent's Name (First, Middle, Last	(t)		-				2. Date of Dea Month			3. Time of Death
##C	Physici /Medio		Alice May Be	cker						March	30		2:25-PM
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City	, Town, or Locatio	n of Death	-	4c.	County of Dea	th
	- I	e Le	Sina Hospit		ultimo			altimore		,			
	Funeral		5. Social Security Number 6. S	ex 7. Ag □M 2√2 F	je (In yrs. last 82	birthday) Yrs.	Months		er 24 Hrs. Min.	8. Date of Birt (Month, Day Aug. 18	h v, Year)	9. Bir	thplace (State or Foreign ountry) MTD
	Director		217-18-1776 Usual Residence of Decedent		02					Aug. 10), 1	923	MD
	yland		10a. State 10b. County		10c. City, T								10d. fnside City Limits
	e-f st	ctor	MD Carrol	L	We	stmi	nste	ſ					1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Z	p Code			-	zen of What C	ountry?
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f show aumatic event, the Madical Examinar must be notified at	62	205 St. Mark Way			147.1		21158		- W N -		JSA	- day fading
	ltems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?		13. \	Was Dece If Yes, sp	edent of Hispanic (ecify Cuban, Mexic	oan, Puerto	Rican, etc.)		14. Race - Am Black, Whi	
36	al', or	by F	Widowed 4 Divorced	1 □Yes 2√□1 ff Yes, GiveA Year or Dates:	110		1 🗆 Yes	2 No Speci	fy:			Specify:	White
Maryland 21215-0036	within 72 hours after ene. than "natural", or Ite		15. Decedent's Ed	Jucation	1	6a. Deced	dent's Us	ual Occupation ork done during m	act of worki	22	16b. Ki	nd of Business	/Industry
215	thin 7	Completed	(Specify only highest gra	College (1-4or 5	5+)	life. l	DO NOT	use retired)	OSI OF WORK	ng .			
2	filed wi Hygien Sther th	Sol	10			Sale	es As	ssociate		(First Maintelle		Mart	
ğ	ould be fil Mental H erked ott	Be	17. Father's Name (First, Middle, Last) Melvin J. Barl:							(First, Middle, Noethen		Sumamej	
<u> </u>	should and Men s marke umatic	²	19a. Informant's Name/Relationship			19b Mailir	ag Addres	ss (Street and Nun				r Town State	Zin Code)
Ma			Melvin R. Barlipp	(Brother				Real, F					
ē,	ss 1 and of Health item 27		20a. Method of Disposition		20b. Plac			ame of other place)		ate		ocation - City or	
altimore,	permit. Pages Department of I Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi					Cemetery	4/4/0	6	Ba1t	imore,	MD
a	partm ports y inju		21. Signature of Funeral Service Licer	1500		-							
<u> </u>	88 = 88		Duan L.	. Haight				n Adres de R T FUNERA sville, M				5-1400	JX 193)
Ι.			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that daused one cause on each li	d the death. I	Do not ent	er the mo	de of dying, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	a Segs	18								8 Days
	/Medical Examiner		Tesuring #1 deality	Due to br as	a consequen			. 1	0	4 5			8 1
		Ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequen	nce of):	ict (au	vescilas	(000)	Castion	_		0 1742
	ate be executed sysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
ó	le be executed ysician and e burial-transit		resulting in death) Last	Due to (or as	a consequen	nce of):							
3760	ate be nysicii he bu	Ical		d									
x 68	leath certificate attending phy I for use as the	Physician/Med	IF FEMALE:	00.14							-		
Вох	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal de	eath 3		pregnancy				23d. Date of de Month	livery Day Year
o.	he de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∏Pregnant at 9☐Unknown	time or death	n 5L	Other (specify)					
Division of Vital Records, P.	res that the de signed by the a be detached f	by Ph	Part II. Other significant conditions of	ontributing to death t	out not resulting	ng in the u	nderlying	cause given in Pa	rt I.	23e. Did to	obacco u	use contribute t	o the cause of death?
rds	quires n sign uld be	q pe								101	res 2	□No 3□P	robebly 4. Onknown
000	aw requir s been si 2 should I	Completed								24a. Was		24b. Were a	utopsy findings available completion of cause of
æ	The faw ite has page 2	E O									rmed? 2 ⊒ No	death?	s 2 No
ţ	ien: artifica ctor, p	BeC	25. Was case referred to medical examiner?						ace of Death	(Check only o			
<u>~</u>	hysic his ce il dire	ျ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie		VOutpatier				me 5□Resid			ecify)
L O	ing P	i.io	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ay Year) 28	3b. Time of Injury	f M	28c. Injury at Work? 1 ☐ Yes 2		28d. Describe I	now injur	y occurred	
Sic	death death stor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not b	e Ogo Diogo of In	iury - At home	a farm str				28f. Location (S	Street an	d Number or F	ural Route Number,
<u>≤</u>	lor A after Direct	Certification:	4 Homicide determined	building, et	tc. (Specify)	o, .a, a	1001, 10010	ny, 511155		City or Tov	vn, State	9)	,
	To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Pt	ysician: To the best	of my knowle	edge, deatl	h occurre	d at the time, date	and place,	and due to the	cause(s)	and manner a	s stated.
	he Ho in 24 he Fu pletely	Medical	(Check only 2 Medical Exar	niner: On the basis of and manner st	of examination	n and/or in	vestigatio	n, in my opinion, o	seath occurr	ed at the time,	date and	d place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of centifier				2	9c. License numbi				te signed (Mon	
,	A			- D	5			RES- C	000		Ma	sch 3	0,2006
	1		30. Name and address of person who	completed cause of o				116	R	Himore			
1 2	C.	ate	31. Date filed (Month, Day, Year)	\$2. Regist	rar's Signatur	1 H	920	iteal of	Doc	HIMOER			
	Regist		APP O 6 200		80	Acar	60 0						

DHMH 17 Rev 1/2001

Faturat Known as Allee Becker

		•	1 - For State Registrar	State of Maryland		irtment of H tificate of L			giene Reg. No.	006	10684
			1. Decedent's Name (First, Middle, Last)	1				2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Thomas Edu	oard Burn	22			Month	, Z3		13:00 PM
7	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Dear			ounty of Death	•
П			The Johns Hopki	ns Hospital		Baltl	more 1	21+4	n,	/a	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h Y Year)	Coun	
	Director	}	212-44-3/94	^{M 2∐F} 62	Yrs.			April	14, 1	943 Ma	ryland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10	Od. Inside City Limits
	Mary	ō	PA York	Ne	w Fre	edom					1 ☐ Yes 2 🖾 No
	28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizer	n of What Coun	try?
	death with the Maryland me 23a or 28a-f ehow r must be notified at	<u>a</u>	18158 Amanda Lane			17349			Unit	ed State	es
	death me 2	Funeral	11. Marital Status 1	Was Decedent Ever in U.S. Armed Forces?	. 13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Specify Yes or No	14.	Race - America	
٥	after or ite	Ī	1 ☐ Never Married 2 💆 Married	1 ☐ Yes 2 🏋 No If Yes, Give		Tes, specily Cubal I⊡Yes 2XINo	Specify:	ito riican, etc.)		Black, White, o	ite
2	be filed within 72 hours after ital Hygiene. Id other then "naturel", or ite event, the Medical Examina	d by	3 Widowed 4 Divorced	Year or Dates:							
<u>V</u>	"nat	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	luring most of wo	orking	16b. Kind	of Business/Inc	lustry
7	withir	g	Elementary/Secondary (0-12)	College (1-4or 5+)		Accountar			Stee	1	
2 2	filed with Hygiene. other ther		17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Su	imame)	
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan to Mentail Hygiene. Tarked other then "naturel", or iteme 23e or 28e-f ehow marked other then "naturel", or iteme 23e or 28e-f ehow marked event, ite Medical Examinar must be notified at	To Be	John Thomas Burns				Nellie	Louise W	hite		
Ä	should ind Men marke umaric	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street a	and Number or R	lural Route Numbe	or, City or T	own, State, Zip	Code)
	and 2 ealth a m 27 is		Barbara Burns / wi	fe	181	58 Amanda	a Lane N	ew Freed	om, PA	A 17349	
Š.	of He		20a. Method of Disposition	000	ce of Dispo	sition (Name of natory or other place	9)	Date	20c. Locat	tion - City or To	wn, State
Ĕ	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3 □Re 4 □ Donation 5 □ Other (Specify)	Dula	aney V	Valley Mer	norial 3	3/27/2006	Du1	aney Va	lley, MD
Baltimore,	permit Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any niury or other traumatic evone.		21. Signature of Funeral Service Licens	0 1 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22	. Name and Addres	s of Facility An	brose Fu	nera1	Home,	Inc.
n_	89 5 9		- Wan A	Melyon	13	328 Sulph	ır Sprin	ng Rd Arb	utus,	Maryla	nd 21227
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. e cause on each line.	Do not ente	er the mode of dying	g, such as cardia	ic or respiratory ar	rest,		Approximate Interval Between
1	nysician	. 1	Immediate Cause (Final disease or condition	DNeyma	tosis	s of s	mali G	sowel			Onset and Death
	/Medical Examiner		resulting in death)	Due (or as a conseque							
	LAGITITIE		Sequentially list conditions, b.	Mesent	eric	ische	mia				3 Days
V	ed isit	Jue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ince ory.						H Dave
	xecut and	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):	N					1 Enys
8760	death certificate be executed e ettending physicien and od for use as the burial-transit	dical E									
89	ificate g phy as the	edic									
Rox	eath certific ettending p I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	Sc. If yes, outcome of pregnand		T			230	d. Date of delive	ry
Ď	death e ette ad for	Icla	in the past 12 months?	1☐Live birth 2☐Fetal d 4☐Pregnant at time of dea		Ectopic pregnancy Other (specify)				Month	Day Year
		hys	9 Unknown	9□ Unknown							
Š.	law requires that the es been signed by th 2 should be detache	by F	Part II. Other significant conditions con-	tributing to death but not result	ting in the ur	nderlying cause give	en in Part I.				e cause of death?
ğ	w requir been si should I	ted						10)	res 2□t	No 3 ☐ Prob	ably 4 Nunknown
Vital Records,	lawr es be	Completed						24a. Was autop	an 2	24b. Were autop	osy findings available inpletion of cause of
r =	The lav	POS						perfo 1 ☐ Yes	med?	death?	2 No
ita Ita	iician: Th certificete rector, pag	Be (25. Was case referred to medical examiner?	900				eath (Check only c	ne)		
	G in X	မ	1 Tes 21 No		R/Outpatien		- 4 C I I I I I I I I I	Home 5 Resid)
ב	ing After une	on:	27. Magner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	rat (? /es 2 □ No	28d. Describe I	now infury o	occurred	
<u> </u>	r Attending er death. rector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne farm etr		162 7 100	28f Location /5	Street and N	Jumber or Rura	Route Number,
É	i di ti	Certification;	4 Homicide determined	building, etc. (Specify)	10, 141111, 3(11	soi, lactory, office		City or Tox		vollipor of the a	Thouse (Valle)
	Hospital 24 hours a Funeral I		29a. Certifier 1 Certifying Phys	ician: To the best of my knowl	ledge, death	occurred at the tim	e, date and plac	e, and due to the	cause(s) an	nd manner as st	ated.
	To the Hospital within 24 hours a To the Funeral completely filled	Medicai	(Check only 2 Medical Examin one)	er: On the basis of examination and manner stated.	on and/or inv	vestigation, in my op	oinion, death occ	urred at the time,	date and pl	ace, and due to	the cause(s)
	To the To the Complet	ž	29b. Signature and title of certifier	. ~ in -		29c. License				signed (Month, I	
•				W.D		RES	5-000	,	Marci	h 23 .	2006
	10		30. Name and address of person who con	mpleted cause of death (Item 2	23a) (Type,	Print)				200	2006 and 21287
	10		YINGWEL Lum	600 Nor	-th	wolfe	Street	r Balt	more	Maryl	and 21287
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2006	32. Registrar's Signatu	GORAL						
1	- J		MILL O O COO	American A	•						

,			For State Registrar	State of Marylan		ment of He		Mental H	ygiene ()	06	10685
	Dhysisi		1. Decedent's Name (First, Middle, La					2. Date of D		Year	3. Time of Death
	Physici /Medi		Kaymona _	frome Bro				APRIL		2006	5:49A. [™]
	Examir		4a. Facility Name (If not institution, giv 500 BLK。MOUNT STI		40	BALTIMO	Location of Deal RE	ın	4c. Coun	ty of Death	t
	Funeral Director		21 12 1504	ex 7. Age (In yrs.)		Under 1 Year onths Days	If Under 24 Hrs Hours Min		3 1979	Cou	olace (State or Foreign ntry)
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County		y, Town or Location						10d. Inside City Limits 1 🏋 es 2 ☐ No
	ter death with the Maryland freme 23s or 28s-f show frer must be rigitied at	Funeral Director	10e. Street and Number 3414 Kenvi	on Avenue		Of. Zip Code	1213		10g. Citizen o	1 What Cou	ntry?
920	or ite	þ	11. Marital Status 1 Xivever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	.S. 13. Was	Decedent of His s, specify Cubar Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)		ace · Ameri ack, White,	
1215-0	n 72 "na edic	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		life. DO N	s Usual Occupa of work done di NOT use retired)	uring most of wo	orking	16b. Kind of		Printing
Maryland 21215-0036	be filed tal Hygi d other event, I	To Be Co	17. Father's Name (First, Middle, Last, Raymond Br	_			18. Mother's Na	me (First, Midd	le, Maiden Suma	•	., ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	permit. Pages 1 and 2 should be I Department of Health and Menial Importent: if Item 27 is marked or eny injury or other traumatic eve any injury or other traumatic eve ance.	-	19a. Informant's Name/Relationship (19b. Mailing Ad 4729	Park	Heigh	, ,	ber, City or Tow	—	Code) MD 21215
Baltimore,	Pages 1 ament of He ant: if itan		20a. Method of Disposition 1 ☎Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Place of Disposition emetery, cremator 1+, 2160	ry or other place		Date 11/2004	20c. Location Balti		
Ball	permit. Departr Import. eny inj		21. Signature of Funeral Service Lices	Six Six	22. Na Com 119-	me and Address LPASSION -121 S.S	- Funt Stricker	eral se	ervicas E Balto	MD:	21212
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death one cause on each line.		4 1	, such as cardia		arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequent	uence dt):	., ., ., .					
	be executed icien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence) Due to (or as a consequence)							
68760	ficate be executed physicien and is the burial-transit	edical	· ·	d							
P.O. Box	The law requires that the death certificate te hes been signed by the ettending physiage 2 should be deteched for use as the	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	I death 3 Ect	opic pregnancy ner (s <i>pecify)</i>				ate of deliv Jonth	ery Day Year
	n requires that the been signed by should be detected	ed by Pt	Part II. Other significant conditions (contributing to death but not res	ulting in the under	lying cause give	n in Part I.		tobacco use co Yes 2 (No	ntribute to t	he cause of death?
Vital Records,		Completed						pe	as an 24b lopsy formed? 2 \(\sum \) No	prior to co death?	opsy lindings available ompletion of cause of
/ita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Harrisol.		1 04		ath (Check on)			
of o	Phys this al dii	- T	1 XYes 2 No 27. Manner of Death		ER/Outpatient 3 28b. Time of		· L / Haroling		sidence 6X00		»SCENE
ion	ittending I death. ctor: After / the funer	ation	1 □Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year)	5=44 A	28c. Injury Work U 1 ☐ Y	? 'es 2 0 No	Subjec	t wa	- 1	ot
Division of	or A Oire in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specifi	y) ;	lactory, office		281 Location City or 7 Street	(Street and Nur own, State) 5	nber or Run	al Route Number, K Mount
	Hospital 24 hours e Funerai I	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Pl 2 ☑ Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death occition and/or investi	curred at the time	e, date and place inion, death occ	e, and due to thurred at the time	e cause(s) and re, date and place	manner as s	stated. o the cause(s)
	within 2 To the comple	Me	29b. Signature and title of certifier	and mainer stated.		29c. License	number		29d. Date sign	ned (Month,	Day, Year)
			b him	w, mis		o.c.	M.E.		APRIL 1	, 2006	5
	\mathcal{L}		30. Name and address of person who	-	n 23 <i>a</i>) (Type, Prin	t)			ORE, MAI		
	Sta	te	31. Date liled (Month, Day, Year)	32. Registrar's Signa					,		
	Regist	ar	APR 0 6	2006 January Signa	S. Agas						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Dav Year **Physician** APRIL 1:18 AM 2006 5 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Birthplace (State or Foreign
 Country) **Funeral** Days Months Hours 1**X**M 2□F Director 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County 27 is marked other than "naturel", or iteme 23a or 28a-f show treumatic event, the Mudical Examinar must be notified at 1 Ces 2 □ No Director 10g. Citizen of What Country? 106 and Number 10f. Zip Code Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 Married 1 Never Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Completed by 3 ☐ Widowed 4 ★ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 i Opportment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "net, any niury or other treumatic event, the Madical once. 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be JKNOWN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 20b. Place of Disposition cemetery, crematory 20a Method of Disposition

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS SYNDROME 1 day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 months Acute Renal failure on chaonic renal insullicience Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit 2 months Congestive heart tailune Due to (or as a consequence of): Peq Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. the à sete has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan certificete has autopsy 2 No 1 Yes 1 ☐ Yes Division of Vital After this certification funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Nnpatient ဥ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) To the Hospitel or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Certification: 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 25s Certifier 🖆 Constituting Physician. To the best of my knowledge, death oncurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT 2438946 APRIL 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL, MO GHAFOOR, mB

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Challes.

		State of Maryland / Department of Health and M	-	_	10687
		1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)	Reg 2. Date of Death	g. No. U U U	3. Time of Death
Physici		Marguerite Jacqueline Beauchemin	Month	27/2006	11.30a ^M
/Medic Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Lanham		4c. County of Death	Georges
Funeral Director		5. Social Security Number 493-50-3051 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) Cou	place (State or Foreign htry)
Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Prince Georges Lanham Maryland			10d. Inside City Limits
with the 3a or 28a	Funeral Director	10e. Street and Number 6833 Nashville Road 10f. Zip Code 20706	10	g. Citizen of What Cou US	ntry? A
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show appringury or other treumatic event, the Medical Exam art must be notified at ance.	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 450 viorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2000 If Yes, specify Cuban, Mexican, Puerto 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
ithin 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of works) iife. DO NOT use retired)	ing	6b. Kind of Business/Ir Kelly Sec	
filed w Hygier Other th	e Cor	12 5+ Secretary / Editor 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Mi	, , , , , , , , , , , , , , , , , , ,	
uld be Mental rked c	To Be	Jack Dotta	Marie	Weis	
and 2 sho ealth and P m 27 Is ma	Ċ	19a. Informant's Name/Relationship (Type, Print) Olivier Beauchemin / Son 19b. Mailing Address (Street and Number of Rur. 6833 Nashville Rd, Lar	nham MD 2	20706 State, Zi	o Code)
Pages 1 and of He ant: If Item		1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Burial 2 ☑ Crematory or other place) 1 □ Burial 2 ☑ Crematory 2 / 2	28/06	oc. Location - City or T Baltimore	MD
permit. Departimporte any inj		21. Signature of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stev 1501 Fast Fort	avenue	, Baltimo	21230 le, Inc. ere MD
Physician (Madical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	or respiratory arres	st,	Approximate Interval Between Onset and Death
/Medical Examiner	П	Due to (or as a consequence or):			
f 00, te be executed ysician and te buriat-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
death certifica e death certifica he attending phe defor use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Ectopic pregnancy 5 Other (specify)		23d. Date of deliv	ery Day Year
w requires that the bean signed by the should be detach	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
VICIN DECOLOR Istcian: The law require s certificate has been si lirector, page 2 should I	ompieted		24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
ysician: The list certificate hadrector, page	Be C	eyaminer?	h (Check only one		
Physic this c	- To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Aesider 28d. Describe how		fy)
Attending Physical Colors of death. ector: After this by the funeral	ation	1 Matural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No		• •	
DIVIS el or Atte s after des at Directo	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
To t Within	Σ	29b. Signature and title of certifier 29c. License number MN33253	29	d. Date signed (Month)	Day, Year)
,0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Cosin III Janing ST NW	ASHIN	Grow DC	20010
Sta Regist		31. Date filed (Month, Day, Year) APR 0 6 2006 APR 0 6 2006			

			ľ	1- State of Mar	•	artment of H rtificate of L		lental Hygier	ZUUh	10688
		Physici		Decedent's Name (First, Middle, Last) William Bond				2. Date of Death	22, 2006	3. Time of Death
	* 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/Medio Examir	- X-6	4a. Facility Name (If not institution, give street and number) Maryana General A	bispital	4b. City. Town, or Bultin	rore Ci	ty	4c. County of Death	
		Funeral Director		213-44-2645 ¹ ♥ ^{M 2□} F	In yfs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye May 23, 1	ar) Cou	place (State or Foreign ntry) ington DC
		and w		Usual Residence of Decedent 10a. State 10b. County 1	Oc. City, Town or Lo	cation				10d. Inside City Limits
		Manyl f sho	Ö	MD Baltimore	Halet	horpe				1 ☐ Yes 2 ☑ No
		r 28a	Funeral Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
		h with	a D	1920 Woodspring Avenue			21227		USA	
1		or Items	ner	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
Z	39	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Medical Exeminer must be mailfied at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖔 No	Specify:		Specify: Whi	Lte
2	21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing most of work.	ing 16b	. Kind of Business/fr	dustry
(10)	121	d within giene. rr then	ф	Elementary/Secondary (0-12) College (1-4or 5+)	iiie.	chef	,		art school	
	C	be filed tal Hygie d other		17. Father's Name (First, Middle, Last)		Clier	18. Mother's Name	e (First, Middle, Maid		•
3	Maryland		To Be	Andrew Patrick			Rosa A.	Zollenhof	fer	
2	ary	w	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rura	al Route Number, Ci	ty or Town, State, Zij	o Code)
12	Ž	TENE		Sandra Bond/former spouse				Columbia,		
3	Baltimore			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 QOther (Specify) in state	20b. Place of Dispo cemetery, crea	esition (Name of matory or other plac		Date 20c	. Location - City or T	own, State
2	Balti	permit. Pages Department of Important: If II eny injury or once.		21. Signature of Funeral Service Licensee Ronald S. Wade, Dire	ctor S	Name and Address tate Anat altimore,	omy Board MD 2120	1 655 W. B	altimore	Street
		Physician		23a. Pant. Enter the disease, or complications that caused it shoot, or heart failure. List only one cause on each line Immediate cause (Final disease or condition	ne death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	- 46	/Medical		resulting in death)	consequence, of):	,				
	*	Examiner	<u>_</u>	Sequentially list conditions. b. Due to or as a	consequence of:		,	~ / /		
W		ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	Gastr	Toks	timal	Bleedi	na	
2	ń	ate be executed thysicien and the burial-transit	Examine	that initiated events	consequence of):)	
Och	8760,	ite be iysicie ne bur	dical	d						
3	9	artifica ing ph e as th	Med	IF FEMALE:						
a de la company	D. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
	ls, P.O.	w requires that the de been signed by the s should be detached t	by Phy	Part II. Other significant conditions contributing to death but	not resulting in the u	inderlying cause give	en in Part I.	23e. Did tobacc	co use contribute to	. /
٠,	Ö	requi	eted	77160101 112000						
W	Division of Vital Records,	Physician: The law this certificate has t al director, page 2 s	Completed by					24a. Was an autopsy performed	!? death?	opsy findings available ompletion of cause of
۳.	ital	an: T	1 40	25. Was case referred to medical			26. Place of Deat	h (Check only one)	100	20.10
	₹ <	nysici nis cer direc	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	er: 4 🖺 Nursing Ho	me 5 Residence	e 6 ☐Other (Speci	fy)
tz	0	Attending Physician: r death. sctor: Atter this certifica by the funeral director, p		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day)	Year) 28b. Time o	Wor		28d. Describe how i	njury occurred	
iel	sio	uttendi death. ctor: A y the fu	cati	2 Accident investigation	A hama farm		Yes 2 □ No	79f Location (Ctrop	t and Number or Rui	ral Pouta Number
n	Divi	5 ± ± 5	Certification:	4 Homicide determined 286. Place of injur	y - At home, farm, st (Specify)	гевт, тастогу, опісе		City or Town, S	tand Number of Hur tate)	ai noute Number,
W		To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state	xamination and/or in					
		within To th comp	Me	29b. Signature and title of cartifier ,		29c. Licens	e number	29d.	Date signed (Month	Day, Year)
				DR. CHANCE	ALL SING	H 89	537		0122/6	16
				30, Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print)	VII ball	6	an 1/2	ento
				Clan Chal Orgh,	's Signature	7011ll	1 yund	ormer	al No	qual
	196	St Regist	ate rar	31. Date filed (Month, Day, Year)	's Signature		~			

State of Maryland / Department of Health and Mental Hygiene Registered Item #20a-c&22 Per FH C854(1149416/06D994th Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear James Arthur Bauer Physician March 28 2006 8 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Lusby 50 Appeal Lane Apt. 121 | Il Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Oct 27, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Pennsylvania 1√ M 2□ F 1945 Yrs. 207-36-3597 Director 60 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b County th and Mental Hygiene. ?7 is marked other than "nstural", or itsms 23a or 28a-1 shov traumatic event, the Medical Examinetr-sual be netified at 1 ☐ Yes 27 No Director Lusby MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20657 USA 50 Appeal Lane #121 Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) boating 4 boat builder 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill iment of Health and Mental H tant: If Item 27 is marked other Be Virginia Quigley James Arthur Bauer Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1302 Quail Run Drive Jacksonville, AL 36265 Robin Bauer/former spouse other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Riverdale Park Department of H Important: If ite eny injury or ot once. 1 ☐ Burial 2 remation 3 ☐ Removal from State 4/07/2006 Riverdale, MD 4 □Donation 5 ₩Other (Specify) in state Crematory Rate and Address of Facility Thibadeau, Mortuary Service, P.A. States and Address of Facility Thibadeau Mortuary Service, P.A. Baltimore, MAVe, 1996 level Sivler Spring Md 21. Signature of Funeral Service Ronald wade, mone 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ap200110 Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ol). Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 NO 2 ☐ ER/Outpatient 3 ☐ DOA After thi tuneral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 289. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAINASIMD PO BOX 269 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 6 2006

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 14:04 2006 William & Brown april /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Birthplace (State or Foreign Country) 13800MM Melen No. S. W. 7. Age (In yrs. last birthday) Yr Under 1 Year 5. Social Security Number 6. Sex Cumberland If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours 1**№**(M 2□ F 214-72-8848 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TXYes 2 □ No Director MARYLAND N/A BALTIMORE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 5521 BELLE AVENUE 21207 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Amed Folces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☒ Married Specify: BLACK 1 ☐ Yes 2 🛣 No Specify Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK FOOD SERVICE 12yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WM GARFIELD BROWN SR. MARION TERRY ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion M. Sisco/Mother 5521 Belle Ave, Baltimore, Maryland 21207 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 04-07-06 LAUREL, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Juneval Service Licensee 1206 W NORTH AVENUE Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. 5cp 51 5 one week Due to (or as a consequence of): intection Physician/Medical Examiner 1mm uno UITUC deticiency Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Raposi's Sarcone ut the þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 1 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 □ Nursing Home 5 □ Residence 6 ☑Other (Specify) ∫ 4) 1 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 / Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2006

Cumberland Maryland

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28e-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical

Examiner

anding physician and use as the burial-transit

or Attending Physician: The law requires that the death certificate be executed

this certificate has page

After

after death. Director: Aft

To the Hospital or Atter within 24 hours after der To the Funerel Directo completely filled in by th

funeral director,

Box 68760,

Division of Vital Records, P.O.

Baltimore, Maryland 21215-0020

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

al EN ROAM

Day, Year)

APR 0 6

31. Date filed (Month.

	1 - For State Registrar	State of Maryla	and / Depa	artment of H	ealth and M	lental Hy	-	6 069
Physician	Decedent's Name (First, Middle, Last	,				2. Date of De Month	ath Day	3. Time of Death
/Medica	Raymond Samuel Bu			41.07 T	1	04_		206 1:55 74
Examine	1.1.	are Hospita	1.1	PACA A	Location of Death		4c. County Balto	
Funeral	5. Social Security Number 6. S	ex 7. Age (In yi	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
Director	107 05 5100	XM 2□F	87 Yrs.	Months Days	Hours Min.		y, Year)	Pennsylvania
and	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Maryl			altimore					1 ☑ Yes 2 ☐ No
ind S. 6 after death with the Mark terms 23a or 28a-1 or Intermet by notitied other must be notitied.	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
23a o 23a o	3700 Ridgecroft F	Road		21206			U.S.A.	,
7	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Spanic Origin?)	ecify Yes or No	- 14. Race	e - American Indian, k, White, etc.
36 36 and a safe	1 ☐ Never Married 2 📆 Married 3 ☐ Widowed 4 ☐ Divorced	1 XXes 2 □ No If Yes, Give		1 ☐ Yes X☐ No	Specify:	, ,	Specify	T 71 .
May morted S. 121215-0036 led within 72 hours after death with the Maryland tygiene. her than "natural", or items 23a or 28a-1 show it, tha Wolfall Examinat must be notified at	15. Decedent's Ed	Year or Dates:	16a Decer	ient's Usual Occupa	tion		16b. Kind of Bu	sings /Industry
T 1 - 2 1 1 2	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done d DO NOT use retired;	uring most of works	ng	TOD. KING OF DU	sines a industry
121215-00 led within 72 hou tygiene. her than "natura nt, the wordeled	5	2 years	Cor	ntract Mai	nager		Coppers	s Company
be ill your doth	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumami	9)
Tyla Phowid d Men marks marks		Super Original	401.44.00		Irene Un			
Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma Ma M	19a. Informant's Name/Relationship (7) Virginia M. Burne		3700	g Address (Street a Ridgecroi	nd Number or Rura Et Road,	<i>Baltimo</i>	or, City or Town, : ore, MD	State, Zip Code) 21206
Baltimore, Maryland 212' Deartimore, Maryland 212' Deartiment of Health and Mental Hygiene. Important: If item 27 is marked other than many injury or other traumatic event, in Manca.	20a. Method of Disposition			sition (Name of natory or other place		ate		City or Town, State
Page nt: iff	1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Tiomovai ilom State	сететету, сгел etro Cre		04-0	4-06	Baltimo	
Balti Dermit. Departm mports. Balti	21. Signature of Fundral Service Licen	-						neral Home, Inc.
00 88 5 8	John and			15 Delair				
Wedical Examiner Transit Examiner		a. Sepsis Due to (or as a const	equence of):	Ficile (r respiratory ar	rest,	Approximate Interval Between Onset and Death
.O. Box 68 the death certifica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	atai death 3 🗆 death 5 🗆	Ectopic pregnancy Other (specify)			23d. Date Mon	o of delivery th Day Year
S, P. Festhaligned I be det	Part II. Other significant conditions co	4 1		derlying cause give	n in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
Cord w require been sit should it	tha stage or	renal disc	case.			1 🗆 Y	es 2 No	3 Probably 4 Unknown
Division of Vital Records, for Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be deriffication: To Be Completed by						1 Tes	med? de 2 2 No 1	fere autopsy findings available for to completion of cause of path? Yes 2 No
of Vil hysicia his cert il directo	examiner?	Hospital: 1 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Other	26. Place of Death 1 □ Nursing Hor			- (C4.)
on of		28a. Date of Injury (Month, Day Year)		28c. Injury	at 2		ow injury occurre	
ision trending death. ctor: Affer funer y the funer fication.	1 Natural 5 Pending 2 Accident investigation	(MONIII, Day 19ar)	Injury	M 1 □ Y	es 2 No			
Division (tel or Attending F ars after death, led in by the trainer Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office	2	28f. Location (S City or Tow	itreet and Numbe n, State)	r or Rural Route Number,
Hospita Purs Puneral tely filled	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	rsician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the time estigation, in my opi	o, date and place, a nion, death occurre	and due to the o	ause(s) and mar	nner as stated. nd due to the cause(s)
To the within 2 to the comple	29b. Signature and title of certifier	2 11 1	-	29c. License	number		29d. Datę signed	(Month, Day, Year)
	James J.	Stule Mn		Do	05772	21	4/3/	06
141	30. Name and address of person who c	ompleted cause of death (Its	em 23a) (Type, F	(int)		11.	h si	2.20-
State	31. Date filed (Month, Day, Year)	11) YUU ty	WKIN.	Somme D	rive 90	HMW.	e, IVID	71251
Registrar	APR 0 6 2006	32. Registrar's Sign	alure 034					

			For State	State of Marylan		nt of Health and te of Death	-	giene 006	10692
70	Physicia		1. Decedent's Name (First, Middle, Las		micha		2. Date of De	Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		1 4b. City	y, Town, or Location of De	ath	4c. County of De	ath
,	Funeral		5. Social Security Number Lass	Eucheran 7. Age (In yrs.	Months	er 1 Year If Under 24 H	rs. 8. Date of Bir n. (Month, Da	rth 9. Bi	inthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	, ,	Yrs.		March 2	x7,1926 N	Carolina
	the Marylan 28e-f ehow	tor	MD NA		y, Town or Location				10d. Inside City Limits 1 Yes 2 □ No
	with the	I Direc	10e. Street and Number 3812 Crans to			1229		10g. Citizen of What C	Country?
ì	ter death w	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U	.S. 13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		nerican Indian, ite, etc.
5-0036	72 hours aft naturel', or	by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		2 No Specify:		Specify: 6	lack
7	d within 72 hours after death with the Maryland jiene. jiene. Ir than "naturel", or Itema 23a or 28e-f ehow the Modical Exemple or mat be notified.	Completed	15. Decedent's Ed (Specify only highest gra Elementae/Secondary (0-12)		life. DO NOT	vork done during most of v	vorking	Hospita	/
nd 21	T 20 5 100	Be Col	17. Father's Name (First, Middle, Last)		Jiaic a		lame (First, Middle	o, Maiden Sumame)	/
Maryland	d 2 should be filed h and Mental Hyg 7 le marked otha traumatic event,	To	19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing Addre	ss (Street and Number or	Rural Route Numb	per, City or Town, State,	. Zip Code)
	1 and Healt Im 2		Margie Talky -	NIECE 20b. F	6/12 Ta	ILS Road	Balto. M.	0 2/207 20c. Location - City of	or Town, State
altimore,	S to I		Burial 2 Cremation 3 Capacity	Hemoval from State Me	adowniage	Cemetery 4	-8-06	Laurel, m	D
Bail (permit. Page Department. Important: if eny injury o		21. Signature of Juneral Service Liven	my	Bary P.	March FlH a	270 Fred	hilton Pass	Butto MD
7			23a. Party. E e the disease, or comp shock or leart failure. List only Immediate use (Final disease r ondition	plications that caused the deat one cause on each line.			hac or respiratory a	arrest,	Approximate Interval Between Onset and Death
7	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consec	-	7111013 40.1	onia.		
150		lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ur as a conseq	uerice of).				
,0	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	uence of):				
68760	ifficate be g physici as the bu	edica		d		-			
Вох	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ectopic			23d. Date of d Month	lelivery Day Year
P.O.	that the deed by the detached		9 ☐ Unknown Part If. Other significant conditions of	9□ Unknown ontributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Division of Vital Records,	w requires tha been signed should be de	ted by					_ 10	Yes 2 No 3□	Probably 4 Nonknown
Reco	The law rie has be age 2 sh	Completed					24a. Was — auto perf 1 ☐ Yes	s an 24b. Were prior to death'	
/ital	cian: ertifica ector, p	BeC	25. Was case referred to medical examiner?	Haaritali		Chan	Death (Check only	one)	
) of	tending Physician: The leath. leath. tor: After this certificate his the funeral director, page	n: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	DOA Cther: 4 Nursin 28c. Injury at Work?		how injury occurred	pecify)
/islo	Attendir r death. ector: Al	Certification:	2 Accident investigation 3 Suicide 6 Could not be	e 28e. Place of Injury - At h	M ome, farm, street, fact	1 ☐ Yes 2 ☐ No ory, office	28f. Location	(Street and Number or own, State)	Rural Route Number,
Ö	urs efte rrai Dir		4 Homicide	building, etc. (Speci					
	To the Hospitel or At within 24 hours effer of To the Funeral Direct completely filled in by	Medical		ysicien: To the best of my knowniner: On the basis of examination and manner stated.			and the second second second	aleke and alama and d	un to the course(s)
	To the To the comp	Σ	29b. Signature and title of certifier Makey up about	$A \circ A :$	2	29c. License number	7465	29d. Date signed (Mo	nth, Day, Year)
	N		30. Name and address of person who NiS. Ruj ip w	completed cause of death (Ite	m 23a) (Type, Print)	on, in my opinion, death of 29c. License number D 005 3	Poickent	zinn Mark s	21136
		ate	31. Date filed (Month, Day, Year)	32 Aegistrar's Sign	ature	•	1012-141	Civil Fried C	
10	Regist	rar	APR 0 6 20	Ub A Pare 1	19000				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Feb. 21 2006 8:40pm Alberta L. Clark /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis 471 Ruffian Court Anne Arundel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 □ F 226-68-5038 60 10/14/1945 VA Director Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location the Maryland 10a State 10b. County 28e-1 show the Medical Exercit er trust be notified at 1 Yes 2 No MD Anne Arundel Annapolis Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23e or 3 471 Ruffian Court 21401 USA death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ②CNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Never Married 2☐ Married filed within 72 hours after 0 1 ☐ Yes 2 X No Specify: Specify. Baltimore, Maryland 21215-0036 black 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) then . Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Importent: If item 27 Is marked other the eny injury or other treumatic event, ITEM ODICE. Dept. Store 12 0 Stock Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Clark Mary A. Jackson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James Clark / Son 471 Ruffian Court Annapolis MD 21401 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Bemoval from State Ebenezer Baptist Church Cem. 3/1/2006 Chileburg, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. Wictor P. Doda 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mon 1h 1400P1 0/10 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 🗷 No 3 Probably 4 □Unknown 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2/1 No 1 ☐ Yes certificate onen To the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specify) 1 ☐ Yes 2 ☑ No 2 his 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Man + r of Death 28a. Date of Injury Certification: (Month, Day Year) After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 900 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 6 2006 Registrar

2.7	Physici	an	Decedent's Name (File	irst, Middle, Last	1)			artment 04/06 tillicate				2. Date of De	aath Dav	OCC Y	ear	3. Time of De	
	/Media	cal	Mary		gnes	orl.	Card	4h Cin T	·	Location		March 2	- 1	County of	Dooth	11:05	P ^M
	Examir	er	4a. Facility Name (If not 240 Inlet	_	street and numb	er)				Location o	r Death						
*	Funeral		5. Social Security Numb		x 7.	Age (In yrs.	last birthday)		Year	If Under 2		8. Date of Bir	th	ne A		el ace (State or Fory)	oreign
(جُنِي	Director		214-24-453	19	⊒м 2 ў ДГ	8	4 Yrs.	Months	Days	Hours	Min.	(Month, Da March		21	MD.	ry)	
	p ,		Usual Residence of Dec	b. County		100 Cit	ty, Town or Lo								110	d. Inside City L	issias
	shov	5		inne Aru	nde1		Linthi									1 ☐ Yes 2	
	the M	Director	10e. Street and Number				DITTELLIA	10f. Zip C	Code				10a Citiz	en of Wha	at Count		
	Mith Sa or	ā	509 Oak G		ad			210								.,.	
	me 2:	Funeral	11. Marital Status	TOVE NO.	12. Was Decede	ent Ever in U		Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No	U.S	4. Race -			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department: If tier 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar minal be notified at once.	by	1 ☐ Never Married 3 🛣 Widowed 4 ☐		Armed Force 1 Tes 2 If Yes, Give Year or Date			If Yes, specif	•	Specify:	, Риепо г	tican, etc.)		Black, Specify:	White, e	ite	
Ŏ IO	2 ho	Completed	15.	Decedent's Edu	ucation			dent's Usual kind of work			of worker	10	16b. Kir	nd of Busin	ness/ind	ustry	
21	ithin 7	nple	Elementary/Secondar		College (1-4	or 5+)	life.	DO NOT use	retired)	ing most	Or WOTKE	'y					
7	led w lygier her th		8	a Adidalla Land			Manui	Eactur	ing	40 Marks	de Nome	/Cinn		per (Comp	any	
and and	be fi	Be	17. Father's Name (First	_								(First, Middle		Sumame)			
<u> </u>	hould d Mei mark matic	2	Leo A. Lat		vne Printl		19h Maili	na Address /	(Street a			oalding		Town St	ate Zin	Codel	
<u>S</u>	id 2 s Ith an 27 is trau		Mrs. Anna			htor									110, 210	3000)	
<u>6</u>	Heal Heal Heal		20a. Method of Dispositi		5 / Daug	20b. F	Place of Dispo	sition (Name	e of	and ellipse		ena, MI		cation - Cit	ty or Tov	vn, State	
Baltimore,	Page ent of nt: if i		1. Burial 2 □Cr 4 □Donation 5 □			818	en Have			'	arch	312006	G1	en Ri	ırni	o MD	
	mit. I		21. Signature of Funera					2. Name and								ne, P.A	
ä	Depa Impo any i		Mark	1. ll. V	anur.	/ Mol	357 1	Seco	nd A	venue		. Glen				•	•
W			23a. Part1. Enter the di	icasca occamo													
			snock, or neart fair	ilure. List only o	ne cause on eac	sed the deat h line.	th. Do not ent	ter the mode								Approximate Interval Between	
-	nysician		Immediate Cause (Fina disease or condition	ilure. List only o	ne cause on eac	h line.			of dying	g, such as	cardiac or	r respiratory a	rrest,			Approximate	
. 19	/Medical		Immediate Cause (Fina	ilure. List only o	a	h line.	TAI		of dying	g, such as	cardiac or		rrest,			Approximate Interval Between	
. 19			Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition	iture. List only o	a. Due to (or	as a conseq	quence of):		of dying	g, such as	cardiac or	r respiratory a	rrest,			Approximate Interval Between	
	/Medical Examiner	nlner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlyin	iture. List only o	a. Due to (or	h line.	quence of):		of dying	g, such as	cardiac or	r respiratory a	rrest,			Approximate Interval Between	
	/Medical Examiner	xaminer	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition	ons, diate	aDue to (or	as a conseq	quence of):		of dying	g, such as	cardiac or	r respiratory a	rrest,			Approximate Interval Between	
	/Medical Examiner	ai Examiner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition from the cause. Enter Underlying Cause (Disease or injur that initiated events	ons, diate	aDue to (or	as a consequence as a consequence	quence of):		of dying	g, such as	cardiac or	r respiratory a	rrest,			Approximate Interval Between	
	/Medical Examiner	dicai	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition from the cause. Enter Underlying Cause (Disease or injur that initiated events	ons, diate	aDue to (or	as a consequence as a consequence	quence of):		of dying	g, such as	cardiac or	r respiratory a	rrest,			Approximate Interval Between	
	/Medical Examiner	dicai	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition from the cause. Enter Underlying Cause (Disease or injur that initiated events	ons, diate	Due to (or	as a consequence as a c	quence of): quence of): quence of):	٦٤	of dying	g, such as	cardiac or	r respiratory a	arrest,	3d. Date c		Approximate Interval Between Onset and Dea	
. Box 68760,	death certificate be executed e attending physicien and of for use as the burial-transit	dicai	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition from the cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE:	ons, diate gry	a. Due to (or b. Due to (or c. Due to (or d	as a consect at a consect at a consect as a	quence of): quence of): quence of): ancy al death 3		c I	g, such as	cardiac or	r respiratory a	arrest,		of deliver	Approximate Interval Between Onset and Dea	ath
. Box 68760,	the death certificate be executed where a street of the attending physicien and ached for use as the burial-transit	dicai	Immediate Cause (Fina disease or condition resulting in dealh) Sequentially list condition fany, leading to immediate. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mon 1 Yes 2 No 9 Unknown	ons, diate gry	Due to (or	as a consequence of pregnatical tat time of consequence of pregnatical tat time of consequence of the conseq	quence of): quence of): quence of): quence of): quence of):	Ectopic pred	gnancy	g, such as	cardiac or	r respiratory a	A A	3d. Date c	of deliver	Approximate Interval Between Onset and Dea	ath
s, P.O. Box 68760,	the death certificate be executed where a street of the attending physicien and ached for use as the burial-transit	by Physician/Medicai	Immediate Cause (Fina disease or condition resulting in dealh) Sequentially list condition fany, leading to immedicause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preint the past 12 mon 1 Yes 2 No	ons, diate gry	Due to (or	as a consequence of pregnatical tat time of consequence of pregnatical tat time of consequence of the conseq	quence of): quence of): quence of): quence of): quence of):	Ectopic pred	gnancy	g, such as	cardiac or	r respiratory a	arrest,	3d. Date o Month	of deliver	Approximate Interval Between Onset and Dea	r th?
s, P.O. Box 68760,	w requires that the death certificate be executed we have a substitution of the strength of t	by Physician/Medicai	Immediate Cause (Fina disease or condition resulting in dealh) Sequentially list condition fany, leading to immediate. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mon 1 Yes 2 No 9 Unknown	ons, diate gry	Due to (or	as a consequence of pregnatical tat time of consequence of pregnatical tat time of consequence of the conseq	quence of): quence of): quence of): quence of): quence of):	Ectopic pred	gnancy	g, such as	cardiac or	23e. Did 1	tobacco us	3d. Date o Month se contribu	of deliver	Approximate Interval Between Conset and Dea	r h?
s, P.O. Box 68760,	w requires that the death certificate be executed we have a substitution of the strength of t	by Physician/Medicai	Immediate Cause (Fina disease or condition resulting in dealh) Sequentially list condition fany, leading to immediate cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mon 1 Yes 2 No 9 Unknown	ons, diate gry	Due to (or	as a consequence of pregnatical tat time of consequence of pregnatical tat time of consequence of the conseq	quence of): quence of): quence of): quence of): quence of):	Ectopic pred	gnancy	g, such as	cardiac or	23e. Did	tobacco us Yes 25 an psy	3d. Date of Month se contribu	of deliver	Approximate Interval Between Conset and Dea	r h?
s, P.O. Box 68760,	w requires that the death certificate be executed we have a substitution of the strength of t	e Completed by Physician/Medical	Immediate Cause (Fina disease or condition resulting in dealh) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent prein the past 12 mon 1	ons, diate only o al ons, diate only o al ons, diate on one one	Due to (or	as a consequence of pregnatical tat time of consequence of pregnatical tat time of consequence of the conseq	quence of): quence of): quence of): quence of): quence of):	Ectopic pred	gnancy	n in Part 1.	ELA	239. Did 1	tobacco us Yes 2[an psy 2 No	3d. Date of Month se contribu	of deliver	Approximate Interval Between Conset and Dea	r h?
s, P.O. Box 68760,	w requires that the death certificate be executed we have a substitution of the strength of t	Be Completed by Physician/Medical	Immediate Cause (Fina disease or condition resulting in dealh) Sequentially list condition fany, leading to immedicause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preint the past 12 mon 1	ons, diate gry	Due to (or	as a consect at at time of consect at at time of consect at at time of consect as a consec	quence of): quence of): quence of): quence of): quence of):	Ectopic pred	c I	n in Part I.	ELA	23e. Did 1 24a. Was auto performed to the control of the control o	tobacco using the second secon	3d. Date of Month se contribu	of deliver	Approximate Interval Between Interval Between Conset and Dea	r h? nown
s, P.O. Box 68760,	w requires that the death certificate be executed we have a substitution of the strength of t	To Be Completed by Physician/Medical	Immediate Cause (Fina disease or condition resulting in dealh) Sequentially list condition fany, leading to immedicause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent preint the past 12 mon 1	ons, diate against to medical	Due to (or	as a consect at at time of consect at at time of consect at at time of consect at a	quence of): quence of): quence of): ancy al death 3 [death 5 [sulting in the u	Ectopic prediction of the control of	c I	n in Part I.	of Death	23e. Did 1 24a. Was auto performed to the control of the control o	tobacco using the second secon	3d. Date of Month se contribu	of deliver	Approximate Interval Between Onset and Dea	r h? nown
s, P.O. Box 68760,	w requires that the death certificate be executed we have a substitution of the strength of t	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in dealh) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent present the past 12 mon 1	ons, diate ig ry ognant at conditions co	Due to (or	as a consect as a	quence of): quence of): quence of): quence of): ancy al death 3 [death 5 [Ectopic pred Other (special other) of the desired of the desired other (special other) of the desired other (special other	gnancy cafy) use give	n in Part I.	of Death	23e. Did 1 24a. Was auto perfu 1 Yes (Check only the State of the Stat	tobacco us Yes 2 5 an psy psy 2 1 10 one)	3d. Date of Month se contribution of the contr	of deliver	Approximate Interval Between Conset and Dea	rnown
ivision of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the results of the state of t	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in dealh) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent present the past 12 mon 1	ons, diate ig ry	Due to (or Due to	as a consect as a	quence of): quence	Ectopic pred Other (special other) of the desired of the desired other (special other) of the desired other (special other	gnancy cafy) use give	n in Part I.	of Death	23e. Did 1 24a. Was auto perfu 1 Yes (Check only the State of the Stat	tobacco use Yes 2 [an psy primad? 2] No one) idence 6 how injury	3d. Date of Month se contribution of the contr	of deliver	Approximate Interval Between Onset and Dea	rnown
ivision of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the results of the state of t	Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list condition and the cause. Enter Underlying Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent present the past 12 mon 1	ons, diate and provided and pro	Due to (or Due to	as a consect as a	quence of): quence	Dectopic prediction of the control o	gnancy Glace Injury Work 1 1 Y	n in Part I. 26. Place 27 4 Num at 28 2 N	of Death rsing Home	23e. Did 1 24a. Was auto performer (Check only or To City or To	tobacco use Yes 2 [an	3d. Date of Month se contribution of 3 (24b. We price deal 1). 24b. We price deal 1.	of deliver Proba re autoport to corr th? Yes (Specify)	Approximate Interval Between Conset and Dea Conset	rnown
ivision of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the results of the state of t	Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in dealh) Sequentially list condition and in the past 12 mone in the pa	ons, diate only o al ons, diat	Due to (or Due to	as a consect as a	quence of): quence	Ectopic pred Other (special other) and other	gnancy crify) use give	n in Part I. 26. Place 27. 4 Null at ? (es 2 1	of Death rsing Hom 2 No 2 d place, a	23e. Did 1 24a. Was auto perfect of the Check only one 18d. Describe	Yes 2 (Street and win, State)	3d. Date of Month se contribution of Month se contribution of Months and Months of Mon	of deliver the to the Proba re autoport to corruth? Yes: (Specify, or Rural er as sta	Approximate Interval Between Conset and Dea Conset	rnown
ivision of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the results of the state of t	To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in dealh) Sequentially list condition resulting in dealh) Sequentially list condition in dealth (Sequentially list condition in the past 12 mon 1	ons, diate ig ry ont conditions co to medical Pending investigation Could not be determined Certifying Phy Medical Exami	Due to (or b. Due to (or c. Due to (or d. Due to (or d. Pregnan 9 Unknow ontributing to deal Hospital: 1 Inp 28a. Date of building visician: To the basiner: On the basiner: On the basiner:	as a consect as a	quence of): quence	Dectopic prediction of the control of the course of the co	gnancy Gla Othe C I Othe C I Othe C I C I Othe C I C I C I C I C I C I C I C	n in Part I. 26. Place 26. Place 27. 4 Nui at 7. 6s. 2 Nui at number	of Death rsing Home	23e. Did 1 24a. Was 2 24a. Was 2 24a. Was 3	tobacco use Yes 2 [an psy prompd? 2] No one) idence 6 how injury cause(s) date and 29d. Date	3d. Date of Month se contribution of Month se contribution of Months of Mont	of deliver Proba re autoport to contith? Yes: (Specify, or Rural er as stad due to	Approximate Interval Between Conset and Dea Conset	r nown
ivision of Vital Records, P.O. Box 68760,	w requires that the death certificate be executed we have a substitution of the strength of t	Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in dealh) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent present the past 12 mon 1	ons, diate ig ry ont conditions co to medical Pending investigation Could not be determined Certifying Phy Medical Exami	Due to (or b. Due to (or c. Due to (or d. Due to (or d. Pregnan 9 Unknow ontributing to deal Hospital: 1 Inp 28a. Date of building visician: To the basiner: On the basiner: On the basiner:	as a consect as a	quence of): quence	Dectopic prediction of the control of the course of the co	gnancy Gla Othe C I Othe C I Othe C I C I Othe C I C I C I C I C I C I C I C	n in Part I. 26. Place 26. Place 27. 4 Nui at 7. 6s. 2 Nui at number	of Death rsing Home	23e. Did 1 24a. Was 2 24a. Was 2 24a. Was 3	tobacco use Yes 2 [an psy prompd? 2] No one) idence 6 how injury cause(s) date and 29d. Date	3d. Date of Month se contribution of Month se contribution of Months of Mont	of deliver Proba re autoport to contith? Yes: (Specify, or Rural er as stad due to	Approximate Interval Between Conset and Dea Conset	r nown
ivision of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be executed the results of the state of t	Certification; To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in dealh) Sequentially list condition and the cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last IF FEMALE: 23b. Was decedent present the past 12 mon 1	ons, diate and provided in the conditions continued in the	Due to (or Due to	as a consect as a	quence of): quence	Dectopic prediction of the control of the course of the co	gnancy Gla Othe C I Othe C I Othe C I C I Othe C I C I C I C I C I C I C I C	n in Part I. 26. Place 26. Place 27. 4 Nui at 7. 6s. 2 Nui at number	of Death rsing Home	23e. Did 1 24a. Was 2 24a. Was 2 24a. Was 3	tobacco use Yes 2 [an psy prompd? 2] No one) idence 6 how injury cause(s) date and 29d. Date	3d. Date of Month se contribution of Month se contribution of Months of Mont	of deliver Proba re autoport to contith? Yes: (Specify, or Rural er as stad due to	Approximate Interval Between Onset and Dea Dea Onset and Dea	r nown

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10695 1 - For State Registrate Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3.40 ston 4 VIYa inia 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death iarrol HOSPITA enter rro If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign Country)
Texas 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 M 20 F Min Days Hours Yrs. 387 70 504 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Carroll Westminster 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 844 Chanter Drive 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married African-1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Soc. Security Adm. / Entrp. Federal Gov't. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Antone Jackson Imma Alford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert G. Coston/ Husband 844 Chanter Drive, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4/8/06 Pleasant Rest Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ur f Funeral ervice Licensee 22. Name and Address of Facility $Wylie\ F/H\ PA$ of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 Part 1. Enter the disease, or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): NOY Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be ၉

Funeral

Director

Worle

rel', or Iteme 23a or 28a-f i Exerciser must be positie

"naturel"

ilth and Mental Hygiene. 27 Is marked other then "nr traumatic event, the Med

permit. Pages 1 and 2 of Department of Health ar Important: If Item 27 is eny injury or other traugnos.

the Maryland

death

Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Examine nding physician and use as the burial-transit Physician/Medical signed by the a Completed by s need certificate has tirector, page 2 s Be ၉ this Director: After the Certification: death. within 24 hours after of To the Funeral Directompletely filled in by

1 ☐ Yes 2 🖼 6

27. Manner of Death

1 Natural

2 ☐ Accident

3 🗀 Suicide

4 - Homicide

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records.

or Attending Physicien:

Hospital

-

25. Was case referred to

2	4a. Was an autopsy performed:	24b.	Were autopsy fi prior to complet death?	ndings available ion of cause of
	1 🗌 Yes	2 □ No	3 Probably	4 DUNHOWN
2	3e. Did tobacc	o use con	tribute to the cau	use of death?

2 \ No

autopsy performed? 1 Yes 1 ☐ Yes 201

		Ec. Hace of Beath (check dilly dre)									
6	Но	spital: 1 Impatient 2	ER/Outpatient 3 DO		DOA Other:	4 Nursing H	Home 5 Residence 6 Other (Specify)				
5 Pending investigatio		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work?		28d. Describe how injury occurred				
6 Could not b determined		28e. Place of Injury - At I building, etc. (Speci	ome, farm, stree	et, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)				

234.				curred at the time, date and place, and due to the gation, in my opinion, death occurred at the time.	
29b.	Signature and title of cer	Clivan	IND	29c License number 24218	29d. Date signed (Month, Day, Year) 04 - 04 - 06

30 Name and address of person who comple	eted cause of death (Item 23a) (Typ	e. Print)	Mala la	-0.	West-mineta	141
DR. Raman	Bkanene	349	Marchim	accing	21150	
31. Date filed (Month, Day, Year)	32. Registrar's Signature					

State Registrar

Medical

DHMH 17 Rev 1/2001

		-	1 - For State Registrar	State of Ma	,	artmer e <i>rtifica</i>				R	eg. No.	06	10696
	Physici		1. Decedent's Name (First, Middle, Las		CAI		20			2. Date of Dear Month	Day 2	2006	3. Time of Death 11:55am
	/Medic	al	SHARON 4a. Facility Name (If not institution, give	KAY	CAV	ALLAI		Location of		APRIL		County of Deatl	
7	Examin	er	4603 FURLEY				TIM		· Bouii			N'A	
	Funeral Director		5. Social Security Number 6. S. 218 68 9539 1		(In yrs. last birthda 48 Yrs.		r 1 Year		Min.	8. Date of Birth Mouth Day JUNE	5 , 1 9	9. Birth	nplace (State or Foreign untry) RYLAND
and	W. T	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			-				10d. Inside City Limits
Mary	d sh	ţō	MD n/a		BALTIM	ORE							1 XYes 2 □ No
h the	or 28a	lrec	10e. Street and Number			10f. Zi	Code			1	0g. Citiz	en of What Co	,
ifh wit	23a c	alD	4603 FURLEY	AVENUE				1206				US.	
d 21215-0036 filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: or iteme 23a or 28a-1 show important: If Item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at another.	by Funeral Director	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		I. Was Dece If Yes, spe 1 ☐ Yes		ispanic Origin, Mexican, Specify:	gin? (Spec , Puerto P	ofy Yes or No- Rican, etc.)		4. Race - Ame Black, White Specify: W	
5-0 72 ho	natur	eted	15. Decedent's Ec		(Gi	edent's Usu	ork done o	during most	of workin	g	16b. Kin	d of Business/	Industry
F F	han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life	ENTA:	ise retired	1)			רביני	TAL	
iled y	lygier ther ti nt, th	S	12 17. Father's Name (First, Middle, Last)	1		ENTA.	L AS			(First, Middle,			
anc d be f	ed of	Be c	NORMAN MacKEN	ZIE SR.					OLYN		1EII		
Maryland of 2 should be file	mark matik	ဥ	19a. Informant's Name/Relationship		19b. Ma	iling Addres	s (Street			Route Number			Zip Code)
M 2 bu	27 is 27 is r trat	ji ji	STEVEN CAVALLA	RO/ HUSBA	AND 460	3 FU	RLEY	AVE	BAL	TIMORI	Ξ, Μ	ID 212	06
ore,	of Hein	F H	20a. Method of Disposition	Damaval from State	20b. Place of Dis cemetery, ci	position (Na rematory or	me of other plac	(8)		2000		ation - City or	
Page	ant: If		1 Burial 2 Termation 3 Temperature 4 Donation 5 Other (Specification)	()	METRO			. 1	1/4/2			IMORE	
Baltimore,	Departr Importu any in		21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or com			1211	CHE	SACO	AVE	NUE B	ALTO		NERAL HOME 21237 Approximate
1760, cliebe executed U		Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bDue to (or as a	a consequence of): a consequence of):	(^	nie						Onset and Death
.O. Box 68 the death certifica	e attending pl id for use as t	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ※Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s		,			2	3d. Date of del Month	ivery Day Year
σ ξ	signed by		Part II. Other significant conditions of	ontnbuting to death bu	ut not resulting in the	underlying	cause giv	en in Part I.		1			the cause of death?
Division of Vital Records, P.O or Attending Physicien: The law requires that the		Completed								24a. Was a autop perfor	sy	24b. Were au prior to death? 1 \(\sum \) Yes	utopsy findings available completion of cause of
of Vita Physicien:	certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:			O#5		of Death	(Check only or	10)		
Of O	this o	<u>۲</u>	1 Yes 2 No 27. Manner of Death	1 Inpatie	nt 2 ER/Outpat			4 🗀 140		ne 545 Resid			cify)
On B	After fune	tlon	1 XNatural 5 ☐ Pending	(Month, Day	Year) Injur	y M	28c. Injur Wor	k? Yes 2∐I		od. Boombo II	O 11 11 12 1 y	00041104	
Division of or Attending	within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ury - At home, farm, c. (Specify)					8f. Location (S City or Tow		l Number or Ru	ural Route Number,
Hospite	within 24 hours after deat To the Funeral Director: completely filled in by the	dical	29a. Certifier 1 Transport Certifying Pt (Check only one) 2 Medical Example 1	ysician: To the best on niner: On the basis of and manner sta	examination and/or	ath occurre investigation	d at the tir	ne, date an opinion, dea	d place, a	and due to the dead at the time, d	ause(s) date and	and manner as place, and due	s stated. to the cause(s)
To th	within To the comple	Me	29b. Signature and title of certifier	^		25		e number			29d. Date	signed (Mont	h, Day, Year)
			> 811 m) >			1)40 P	854	i	U	1/4/20.	06
1	0		30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	Paul P	lace	1 Ba	ultim	nare, M	AD	21202	_
	Sta Regist	- 300	31. Date filed (Month, Day, Year)	2006 32. Redistra	eath (Item 23a) (Typ 22) Sh ar's Signature	Sperk	6						

		For State Registrar			State	of Ma	ryland		artment of I <i>rtificate of</i>				giene Reg. No	UU	5	10697
Physicia /Medic		1. Decedent's Name		le, Last,					CREELY		2	2. Date of De. Month 04	ath Da 02		Year 006	3. Time of Death 8:15 P
Examine	_	4a. Fecility Name (If							4b. City, Town, FOREST	HIL	L			. County of	ORD	
Funeral Director		5. Social Security No. 219-07-9 I Usual Residence of	179	6. Se	M 212 F	_	(In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	Hou	der 24 Hrs. grs Min. M	B. Date of Bird (Month, Da arch I	Year)	1911	9. Birthpl	lace (State or Foreign try) Timore, M
vith the Maryland I or 28a-f show	. [10a. State Maryland	10b. County					, Town or Lo	ocation						11	0d. Inside City Limits
ath with the 23s or 28s	Direc	10e. Street and Nun	nber		re				10f. Zip Code 21014				-	tizen of W	/hat Coun	try?
urs after de ai', or items	by Funeral	11. Marital Status 1 ☐ Never Marri 3 🏿 Widowed		1	12. Was Dec Armed F 1 Yes If Yes, G Year or I	orcea? 2 AN	ver in U.S o		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No			ify Yes or No ican, etc.)	-		k, White,	an Indian, etc. White
i within 72 ho piene. r than "natur the Wedical	Completed	Elementary/Seco	15. Deceder ify onfy highe ndary (0-12) grade	nt's Edu	cation e completed College		+)		dent's Usual Occu kind of work done DO NOT use retire		most of working	7		ind of Bus		
uld be tiled fental Hygi rked other tic event.	To Be C	17. Father's Name (First, Middle,	Last)						18. M	other's Name (Unknow		Maider	n Sumame	9)	
and 2 shoualth and M		19a. Informant's Na		, .	pe, Print)			515 (ng Address <i>(Stree</i> D1d Home	Road			-	or Town, S		Code)
permit. Pages 1 and 2 should be tiled within 7: Department of Health and Mental Hygiene. Important: if item 27 is marked other than "n any injury or other traumatic event. The Meal once.		20a. Method of Disp 1X Burial 2 (` 4 □ Donation	☐ Cremation 5 ☐ Other (5	Specify)		n State		ly Red	osition (Name of matory or other pla			, 2006	В	ocation - (altin	nore,	MD
permii Depar Impor any ir once		21. Signal re of u	160	*		anusad	the death		6415 Bel	air	Road,	Baltim	nore		212	Home, In 206 Approximate
Prrysician /Medical Examiner		shock, or fead failure. List only one cause or , ach line. Inate Cause (Final disease or condition resulting in death) Duft to (or as a consequence of):														
cate be executed physician and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.														7.12.11
= D 0	Completed by Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 20 9 Unknown	months?	2		birth :	of pregna 2 □ Fetal time of de	death 3[Ectopic pregnand Other (specify)	ру				23d. Date Mon	e of delive	ery Day Year
quires that en signed b uld be det	ed by PI	Part II. Other signif	icent conditi	ions co	ntributing to	death bu	it not resu	Ilting in the u	inderlying cause g	ven in P	art I.	23e. Did t				ne cause of death?
	Somplet											24a. Was autop perfo		8	rior to cor eath?	psy findings available mpletion of cause of
sician: Th certificate irector, pag	Be	25. Was case refer examiner? 1 Yes 2		—	tospital:	Inpatier	at 2 🗆	ER/Outpatie	nt 3 DOA	hor	Nursing Hom			6 □Othe	ar (Snacih	w)
	Yes 2 No										ed					
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral		4 Homicide	_/	mined	buil	ding, etc	. (Specify	/)	th occurred at the			City or To	wn, Stat	θ)		
To the Hospital within 24 hours a vithin 24 hours of to the Funeral completely filled	Medical	(Check only one) 29b. Signature and	2 Medice	l Exemi	ner: On the		examinat		vestigation, in my 29c. Licen	opinion,	death occurred		date an	d place, a	and due to	
L S F O		30. Name and addr	ess of person	m who c	M ompleted car	use odd	eath (Item	23a) (Type	D Print)	155	83	14	pri	13	, 20	206
ク		DR. MANU	JEL LA	ZAT]	N, 8	LAW	STRE	ET, AI		MD	21001					
Sta Registra		31. Date filed (Mon	th, Day, Year		732.		ir's Signa	ture	W.							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene dr G85404/06/06dhb Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 4:10 AM **Physician** Lester D. Christopher, Sr. 26 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE WASHINGTON MEDICAL CENTER ARUNDEL BURNIE GLEN ANNE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar. 1, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 € M 2 □ F 218 26 7793 Yrs. 1930 Maryland 76 Director Usual Residence of Decedent worle 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "naturel", or items 23a or 28a-f show or other traumatic event, its Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Severn Directo Anne Arundel Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S. 1834 Cedar Drive 21144 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 h and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) 10th College (1-4or 5+) Maintenance Mechanic Baltimore Air Coil 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Whitby Cleveland Christopher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Depertment of Health at Important: If Item 27 is eny Injury or other traugure. 1834 Cedar Drive Severn, Maryland 21144 Joan Christopher / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland Meadowridge Mem. Park 3/29/2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. - 4001 Ritchie Highway Baltimore, Maryland 21225 manuall 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hetabolic Acido Physician /Medical Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit 25 Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š VOSCULO 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 ☐ Yes 2 1 No ivision of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0032744 March 26, 2006 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) MD 301 Hopital

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2

8 2006

LESTER

THRISTO PHER

2. Registrar's SignAture

amend 24,25,26,27,29 Please Type of Print in Brack Indefible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10 30AM Physician MICHAEL DAWSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MARYLAND HOSPITAL CENTER CLINTON PRINCE GEOLGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours 2 Days 1**∑**M 2□F Yrs Maryland 18, Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location r then "natural", or Items 23e or 28e-f show the Modical Exeminer must be notified at 1 ☐ Yes 2√ No Directo Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 USA 9112 Littlestone Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give The Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: black <u>۾</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mygiene. Elementary/Secondary (0-12) College (1-4or 5+) none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked othin any injury or other treumatic svent 908.8. Leah Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Southern Md Hospital 7503 Surratts Road Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4□Donation 5型Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street man 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner 12 Mg Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Year Day 4□Pregnant at time of death signed by the at id be detached fo 5 Other (specify) 9 Unknown 9 Tlinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown plnods Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 🗆 Yes 1 ☐ Yes 2₽No tor: After this certific the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Specify} \) 1√2 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification; To 1 ☐ Yes 2√2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide

Division of Vital Records, P.O. Box 68760 To the Hospitel or Attending Physicien: within 24 hours a To the Funerel C

Baltimore, Maryland 21215-0036

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

D33268

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABCO

SUPPATTS ROAD

State Registrar 31. Date filed (Month, Day, Year) APR 0 6 2006 32. Pegistrar's Signature

			_ FOI	epartment of Health and Nertificate of Death		ne 2006	10700
2	Physici /Medic		1. Decedent's Name (First, Middle, Last) Howard Duvall		2. Date of Death Month March 2	9, 2006 Year	3. Time of Death 2:06pm M
	Examin		4a. Facility Name (If not institution, give street and number) 16491 Frederick Road	4b. City, Town, or Location of Death Woodbine	1	4c. County of Death	
	Funeral Director	-5	5. Social Security Number 6. Sex 1. Age (In yrs. last birthor 1. Age (In	Months Days Hours Min.	8. Date of Birth (Month, Day, Y) May 19,	ear) (Cou	place (State or Foreign intry) 1D
	aryland •how)r	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o Wood				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the M or 28a-f	Director	10e. Street and Number	odbine 101. Zip Code	10g	. Citizen of What Cou	
	ns 23a	Funerai I	16491 Frederick Road 11. Marital Status 12. Was Decedent Ever in U.S.	21797 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	USA 14. Race - Amer	ican Indian,
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f ehow aumatic event, the Madical Examinational be neitified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 6 No 1 Yes 7 No 1	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	Black, White Specify: Whi	
Maryland 21215-0036	hin 72 ho 9. 8n "natur Medical	Completed	(Specify only highest grade completed) (G	scedent's Usual Occupation live kind of work done during most of work e. DO NOT use retired)	king 16	b. Kind of Business/I	ndustry
d 21	filed will Hygien Sther th	e Con	12 17. Father's Name (First, Middle, Last)	School Bus Aid 18. Mother's Nam	ne (First, Middle, Mai		rtation
ylan	should be land Mental I	To Be	John Willard Duvall		y Velle H	1 ,	
Na	and 2 sh ealth and n 27 le m			ailing Address <i>(Street and Number or Rui</i> 191 Frederick Rd.,			p Code)
altimore,	Pages 1 and of He out. If Item		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 20b. Place of Discernetery, or semestery, or semination	sposition (Name of crematory or other place)	Date 20	c. Location - City or T	
Baltin	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 le marked eny Injury or other traumatic enones.		21. Signature of Funeral Service Licensee	ew Cemetery 4/3/ #ATCHT FUNERATION Sykesville, MD 217		arriottsvi L. P.A. (B	
×	40200		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
r of	Physician /Medical		Immediate Cause (Final disease or condition a. Respirat	orytailure			3 hours
	Examiner	_	Due to (or as a densequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	eal Cancer			2405
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
8760,	cate be executed bhysician and the burial-transit	dicai Ex	resulting in death) Last Due to (or as a consequence of): d.	ь.			
0x 68	death certifica e attending phi d for use as th	/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			22d Date of dolla	
о. В	at the death by the atten tached for u	Physician/Me	in the past 12 months?	3 Dectopic pregnancy 5 Other (specify)		23d. Date of deliv Month	Day Year
rds, P	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Record	0 4 0	Completed	Circhosis of H	neliver	24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
Vital R	ysicien: Th iis certificate director, pag	o Be C	25. Was case referred to medical examiner?	104	th (Check only one)		7
on of	ling Pt J. After th funeral	-	1 Yes 2 No 1 Inpatient 2 ER/Outpa 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) Injure 2 Accident investigation	e of 28c. Injury at	28d. Describe how	e 6 Other (Speci injury occurred	fy)
Division	ol or Attendial after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
	To the Hospitel or within 24 hours after To the Funeral Dire completely filled in b	edical C	29a. Certifier (Check only one) Certifyin J Physician: To the best of my knowledge of 2 Medical Examiner: On the basis of examination and/o and manner stated.	hath occurred at the time, date and place, rinvestigation, in my opinion, death occur	and due to the naus red at the time, date	e(s) and vianner as a and place, and due t	nisted. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier M	29c. License number	G (29d.	Date signed (Month,	Day, Year)
	5	1	30. Name an indiress of erson who completed cause of death (Item 23a) (Type ADD Completed Cause of death (Item 25a) (Type ADD Completed Cause of death (Item 25a	De, Print) 1502 S. Mai	in St N	It Ains	10 2/771
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2006	Sparke		. , , , ,	

			For State Registrar	State o	f Marylan	•	irtment of	f Health an of Death	d Mer		giene	16	10701
			Decedent's Name (First, Michael	idle, Last)						Date of Dea	ıth	V	3. Time of Death
	Physici /Media		FRANK	SALVADOR		DANT	ONI		C	Month 4 –	Day 03-	06 Vear	8:45 AM
	Examir		4a. Facility Name (If not institut	ion, give street and nur	nber)	1 1	4b. City, Town	n, or Location of D	Death	,	4c. Count	y of Death	
			Franklin	5g/uare	Hospi	tal	Kos	edale ar I II Under 24	Hro o	D-1 (D)-1	Da		nore
	Funeral		5. Social Security Number 217–60–0644	6. Sex 1 2X M 2 □ F	7. Age (Inters. 5.		Months Da		Min. d	Date of Birth Month, Day	953	Cour	place (State or Foreign htry) RYLAND
	Director		Usual Residence of Decedent								332	7 12 11	CLER ILVD
	yland how		10a. State 10b. Cour	*	10c. Cit	y, Town or Lo						1	0d. Inside City Limits
	the Marylar 28e-f show	çç	MD E	ALTIMORE			RO	SEDALE					1 Yes 2 No
	ith th	Director	10e. Street and Number 8423 ALLISON	TANTE			10f. Zip Cod	21237			10g. Citizen of		1
V	within 72 hours after death with the Maryland ene.				edent Ever in U.	C 12 1	Mas Dagadant		2 (Specific	Vac or No-	14 Pa	U.S.	A. can Indian,
<u>-</u>	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 📉 M	Armed Fo	rces?	.3.	Yes, specify C	of Hispanic Origin Luban, Mexican, P	uerto Rica	in, etc.)	Bla	ick, White,	
↑ & n K -0036	urs af	þ	3 ☐ Widowed 4 ☐ Divorce		70		∏Yes 2∏XI	No Specify:			Specia	fy: WI	HITE
Fra1	72 hours aft "natural", or	Completed		ent's Education hest grade completed)		16a. Deced	lent's Usual Oc	cupation ne during most of	working		16b. Kind of E	Business/In	dustry
	ithin	gr	Elementary/Secondary (0-12	Ţ	-4or 5+)	life. L	OO NOT use re	tired)			omer.	**	
2	filed w Hygier other th	S	12 17. Father's Name (First, Middle	le (set)		S.	LEEL FAI	BRICATOR	Name /Fi	rst Middle	STEE Maiden Sumai		
200	otal H	Be c	PETER		TONI				UISE	st, Middle,		ECKEI	o1
antoni	s 1 and 2 should be filed within 72 hours after death with the auth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s other treumatic event. The Medical Expirit or must	2	19a. Informant's Name/Relatio		110111	19b. Mailir	a Address (Str	eet and Number o		ute Numbe			
≥ ₹	nd 2 s Ifth ar 27 ts r treu		CYNTHIA DANT				ALLIS				ALE, ME		21237
Da Baltimore	s 1 ag f Hea item othe		20a. Method of Disposition		1 ^	Place of Dispo	sition (Name of	place)	Date		20c. Location		own, State
()	Pages nent of it int: if its		1 🖾 Burial 2 □ Crematio 4 □ Donation 5 □ Other		State	•	CEMETI		-7-20	06	PARKV	TLLE.	MD
=======================================	permit. Pages Department of Pimportant: If ite eny injury or of page.		21. Signature of Funeral Servi	ce Licensee		22	. Name and Ad	dress of Facility (CVACH	/ROSE			
<u> </u>	8 2 2 5 8 C		109			12	211 CHES	SACO AVEI	NUE	ROS	EDALE,	MD	21237
	Physician /Medical Examiner		23a. Part1: Enter the disease, shock, or heart failure. Limmediate Cause (Final disease or condition resulting in death)	a	aused the death ach line. Cor as a conseq bable	Imon	ary f	Irrlst	rdiac or re	spiratory an	rest,		Approximate Interval Between Onset and Death
2 0928	cate be executed obysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 . Vei	or as a consequence of the conse	S	tersis						
O Box 6	eath cert attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live t	tcome of pregna pirth 2 Feta nant at time of d	Ideath 3□	Ectopic pregna Other (specify					ate of delive	ery Day Year
Division of Vital Records. P.O.	ulres that signed I	Ď	Part II. Other significant cond	itions contributing to de	eath but not res	ulting in the u	nderlying cause	given in Part I.			bacco use cor 'es 2 □ No	ntmibute to t 3 ∐ Prob	ne cause of death?
j	w requir been si should	Completed							_	24a. Was	an 24b.	Were auto	posy findings available
ď	he lay e has	E C							-	autop	med?	prior to co death?	ppsy findings available impletion of cause of
7	icien: Th certificate rector, pag	BeC	25. Was case referred to medi	ical				26. Place of	Death (C		2 No	1 🗆 Yes	2/23/140
5	ysici is cer direct	To B	examiner? 1 ⊠Yes 2 ☐ No	Hospital: 1 🔲	Inpatient 2 📈	ER/Outpatien	t 3 DOA	Other			lence 6 🗆 Ot	her (Specil	ý)
o c	ng Ph Ifter th		27. Manner of Death ↑ Natural 5 □ Pen	ding 28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		njury at Work?		Describe h	ow injury occu	rred	
ij	eath.	catl	2 ☐ Accident inve	stigation				I □ Yes 2 □ No					
, į	s after d in Direct	Certification;		mined 288. Place	of Injury - At hoing, etc. (Specif	ome, farm, str y)	eet, factory, offi	се	28f.	Location (S City or Tow		ber or Run	al Route Number,
	To the Hospital or Attending Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director. page 2	Medical	29a. Certifier \ \(\sum_{\chick}\) Certif \ (Check only one) \ \(\sum_{\chick}\) Medic	ying Physician: To the cal Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, death tion and/or in	n occurred at the vestigation, in n	e time, date and p ny opinion, death	olace, and occurred a	due to the d t the time, d	cause(s) and m date and place,	anner as s and due t	tated. the cause(s)
	within 2 To the	ž	29b. Signature and title of cert	ifier	7/		29c. Lic	ense number			29d. Date signe	ed (Month,	Day, Year)
			1 /les	Cel 1-	4/		DE	5442	8		04-6	3-	2006
- 	10		30. Name and address of pers				_	, ,			<u> </u>		
	20		J. T.C. CC		ranklin		are Dr	ive, Ba	1+1m	lore,	NI	21.	237
	Sta Regist	ate	31. Date filed (Month, Day, Ye	ar) 32 F	legistrar's Signa	ature V	A.						•

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** DONDERO MARK 2__ APRIL 2006 1:40A M /Medical 4c. County ol Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE 1029 ROSEDALE AVENUE ROSEDALE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 M 2 ☐ F 579-38-0707 75Yrs. 6-2-1930 Washington, DC Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at MD BALTIMORE ROSEDALE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1029 ROSEDALE AVENUE 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Y☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1959–79 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 2 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry perrait. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Modic one. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) CHIEF PETTY OFFICER UNITED STATES NAVY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DONDERO MARK J. HELEN Η. (GAISER) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOANNA DONDERO/WIFE 1029 ROSEDALE AVENUE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4-7-2006 MIDDLE RIVER, MD HOLLY HILL CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTO., MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** myelodypolasia 3 month /Medical Due to (or as a consequence of): Examiner altown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine burial-transit certificate be executed and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. been signed by the ettending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time ol death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 2 No 1 Yes 1 Yes ospital or Attending Physician: Thours after death.
uneral Director: After this certificate filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check oply one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certlfication: 1 Matural 5 Pending investigation 1 TYes 2 TNo 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m.D 0044629 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Woke St Flinn wi'D 31. Date filed (Month, Day, Year) 32. Projistrar's Signature State APR 0 6 Registra 2006

P.O. Box 68760. Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician EDLAND** MIRIAM 6:00 APRIL 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE SINAI HOSPITAL OF BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours 1□M 2₩F Yrs 218-12-4596 82 MAR. 18, 1924 **Director** MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County or other traumatic event, the Medical Examinar must be notified at 1 Ves 2 No MD Director N/A BALTIMORE 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? ö 2434 W. BELVEDERE AVENUE 21215 'natural', or Items 23a USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black. White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event. Ithe Me Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MORRIS GLICK 0 JENNIE KLEIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARRY EDLAND / SON 8917 MOUNTAINBERRY CIRCLE - FREDERICK, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 04/05/2006 OWINGS MILLS, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign we Funeral Service Dicenses Lase 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dayse on each line. Immediate Cause (Final CARDIOPULMONARY ARREST **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed HYPOTHYROIDISM 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy HYPERTENSION 2 12 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Молth, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061959 APRIL 01,2006 on an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, WHOI W BELVEDERE AVE, BALTIMORE, MD AMAN SIBAL, MD. SINA HOSPITAL OF 31. Date filed (Month, Day, Year) APR 0 32. Redistrar's Signature State 6 2006 Registrar

DHMH 17 Rev 1/2001

LORRAINE EBERHARDT

				Please ¹	Type or Prir						-		_	
			1 - State	1 Tt	State of Ma 20b Per E	-				lealth and N		/	THE S	10704
	à	¥1, 490	RegistrarAmen			H G8	04 47	06/06	"TH"	Dealii	2 Date of De	Reg. No ath		3. Time of Death
	Physici		LORRAINE		EBERHARD'	Γ					APRIL	4,	^{ау} 2006 ^{Үөаг}	1:30 AM M
	/Medic Examin	740	4a. Facility Name (If no	_				· · · ·	, Town, o	r Location of Death		40	c. County of Deat	
	uneral irector	- C - C - C - C - C - C - C - C - C - C	5. Social Security Num 214-50-68	nber 6. Se		e (In yrs. I	ast birthda Yrs	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da MAR. 2	th ly Year	9. Bird 1948	hplace (State or Foreign MD.
8			Usual Residence of D 10a. State	ecedent lob. County		100 Cib	, Town or	Logation						10d. Inside City Limits
Aaryla	shov and at	o	MD.	N/A		Too. Oily		BALTIM	IORE.					11X Yes 2 □ No
the !	r 28a-	Director	10e. Street and Numb			1			p Code			10g. C	itizen of What Co	ountry?
ath wit	23a c		509 RAP	POLLA ST						21224			S.A.	
5-00.50 72 hours after death with the Maryland	n natural and waters rygens. Them 21 is marked other then "natural", or itams 23s or 28s-1 show other traumatic event, the Moulcal Execution must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☒ Widowed 4		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Λ Year or Dates:		S. 1	3. Was Deci If Yes, sp 1 \(\text{Yes}		Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.))-	14. Race - Ame Black, Whit Specify: WH	
2 Pg	atura cal E		1:	5. Decedent's Ed	ucation	-	16a. De	cedent's Us	ual Occup	pation	ting	16b. I	Kind of Business	
ig o	u u	Completed	Elementary/Second	ary (0-12)	College (1-4or 5	5+)	lif	B. DO NOT	use retire	during most of world)	king		OT IN TOM	7
M 50 5	nt, in		11TH 17. Father's Name (Fi	irst Middle Last)	0			HOMEMA	KEK	18. Mother's Nam	ne (First, Middle		OWN HOME	<u> </u>
	Ked o	o Be	SYLVESTE		WSKI						A. KURLI			
and 2 should	27 ls marked or traumatic ev	F	19a. Informant's Nam VANESSA	, ,				-		and Number or Ru URT, WES				
u – I	Item Item		20a. Method of Dispos		D	20b. P	lace of Di	sposition (Na	ame of otherpla	96 S11 S	Date	20c. l	_ocation - City or	Town, State
altimor	ant: If			Other (Specify	Removal from State)	I IOI	Ý RÔ	SARY (EMET	ER Y 04/0				MARYLAND
Ball	Important: If It any injury or o		21. Signature of Fune	eral Service Licen	toes		1			ess of Facility CF ERN AVE.				SON, INC.
	1		23a. Part 1 Enter the	disease, or comp	lications hav caused	the death	. Do not						, 111111111	Approximate Interval Between
Phy	/sician		Immediate Cause (Fi	-	one cause on each li		т.т. т.	IING CA	NCER					Onset and Death
/N	ledical aminer		resulting in death)		Due to (or as			one or	шошт	-				
	ammer	er	Sequentially list cond if any, leading to immo cause. Enter Underly	litions,	b. Dee to (or as	5 80 (8 ad)	rence off:							
pejn	d ansit	Examine	cause. Enter Underly Cause (Disease or in that initiated events	ying jury		,								
oU, e executed	ian and urial-transit	Еха	resulting in death) La	st	Due to (or as	a consequ	uence of):							
-	ohysici the bu	dlcal			d									
× eg	attending physician tor use as the burial	/Me	IF FEMALE: 23b. Was decedent p	vognant.	23c. If yes, outcome								23d. Date of de	livery
death cer	e atte	Physician/Medica	in the past 12 m 1 Yes 2 X	ionths?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			3 □Ectopic 5 □ Other (У			Month	Day Year
T is	d by the	Phys	9 Unknown				thing in the			and Dead	220 Did	obacca	use contribute to	the equal of death?
ecords, P.O.	been signed by the should be detached	þ	Part II. Dther significa	ant conditions co	ontributing to death b	out not resi	iting in th	e underlying	cause gr	ven in Part I.				o the cause of death? robably 4 X Unknown
e ec	s certiticate has be irector, page 2 sh	Completed									24a. Was auto perfo 1 \subseteq Yes	psy ormed?	death?	utopsy findings available completion of cause of
	rtiticat	Be C	25. Was case referre	d to medical						26. Place of Dea			10 10 10	2 2 140
OT VITA Physician:	this certifica al director.	7	examiner? 1 ☐ Yes 2 🗶 N	0	Hospital: 1 Inpatio		ER/Outpa			her: 4 Nursing H				HOSPICE
on C	tter ne	lon:	27. Manner of Death	5 Pending	28a. Date of Inju (Month, Da	y Year)	28b. Tim Inju			ryat ⊮rk?]Yes 2 ⊟No	28d. Describe	now inj	ury occurred	
DIVISION Lor Attending	er deam. rector: A by the fu	flca	2 Accident 3 Suicide	investigation 6 Could not be determined	28e. Place of In	jury - At ho	me, farm							ural Route Number,
	ours arte neral Dire tilled in b	Certification;	4 🗌 Homicide		building, el	с. (Бресіі)	/) 				City or To	wii, Sia		
DIVISION Ne Hospital or Attending	within 24 hours after dear To the Funeral Director: completely tilled in by the	edical			ysician: To the best niner: On the basis of and manner st	f examina								
To the	To th	Σ	29b. Signature and til	tle of certifier				2	-	se number		29d. D	ate signed (Moni	
	1			1					リ	73725			4/4/0	6
	1		30. Name and address		·	•			n	TTMONTING	MD 210	02	_	
	Sta	ate	DR. TARIO	, Day, Year)					W .	TIMONIUM,	ED ZIU	7.7		
	Regist	rar	API	R 0 6 200	32. Registr	1 15	A	342						

		•	For State Registrar	State of Ma	aryland /		artment of H				jiene leg. No: ()	06	10705
			Decedent's Name (First, Middle, Last	0		**			2	. Date of Dea	th	Vana	3. Time of Death
н	Physici		Frederick Geo	rge Ellick						Month	Day 2 . 200	Year	5.35 0 M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of	of Death	April 2	4c. Cou	nty of Death	-
			Fastpoint Nursin	α and reha	hilita	ation	Essex				Ва	ltimo	re
	Funeral		Eastpoint Nursin 5. Social Security Number 6. Se	7. Age	(In yrs. last		If Under 1 Year Months Days		24 Hrs. 8 Min.	Date of Birth	1		place (State or Foreign intry)
	Director		Z13-30-2010	□M 2□F X	73	Yrs.				Aug.24			yland
	pu *		Usual Residence of Decedent 10a, State 10b. County		10c. City, To	own or Lo	cation		-		- 112		10d. Inside City Limits
	sho	5			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								1 ☐ Yes 2 ☐ No
	the N	Director	MD Baltimo 10e. Street and Number	re			10f. Zip Code			····	10g. Citizen	of What Col	
	with po	۵					21224					S.A.	,
	ns 23	era	610 S. 47th Stree	12. Was Decedent 8	Ever in U.S.	13. 1	Was Decedent of I	Hispanic Ori	igin? (Speci	fy Yes or No-		Race - Ameri	ican Indian,
10	riter	by Funeral	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 ☐ N If Fes, Give	lo		f Yes, specify Cub			can, etc.)		Black, White,	
ဗ္ဗ	urs a		3 ☐ Widowed 4 ☐ Divorced	If Pe s, Give Year or Dates:			1□Yes 2□No X	Specify:			Spe	cify: Whi	te
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad		10	6a. Dece	dent's Usual Occu kind of work done	pation during mos	t of working		16b. Kind o	f 8usiness/lr	ndustry
2	thin was	ğ	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use retire	nd)					
7	ygien ygien yer th	ပို	12			I	PostaL Cl						Service
밀	be fill bd oth even	Be	17. Father's Name (First, Middle, Last)							^r irst, Middle, e Naima			
<u>\</u>	should nd Men marke	은	Henry Ellick					<u> </u>					
Baltimore, Maryland	C1 C2 TE C2	1 1	19a. Informant's Name/Relationship (7)				ng Address (Street						p Code)
e,	1 and 4ealth em 27 ther tr	- 33	Joyce Lancaster-D	aughter	20b. Place	7904 e of Dispo	Shore Resistion (Name of	ad Ba	ltimo Dat	re, MD	21219 20c. Locatio	on - City or T	own. State
و	Pages nent of I ant: if its ury or o		1 Burial 2 Cremation 3				sition (Name of matory or other pla	1		2006			
臣	rtmer rtant njury	1	4 Donation 5 Other (Specify 21. Signal we of Funeral Service Licens		Oak 1		Cemetery Name and Address		4/5/			more,	
Ba	Depertit Depertr Imports eny inf		1 A A I A A	11000			224 Easte		una	rles Z	eiler	& Son	, inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused	the death D							.1224	Approximate
	Physician /Medical Examiner	iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)	a. Due to (or as b. Due to (or as	A free a consequence	co of):	lestic n Mé	Car	rdcol VS	las Cev	Par i	d seco	Interval 8etween Onset and Death
68760, 🖄	The law requires that the death certificate be executed sie has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	edical Examiner	that initiated events resulting in death) Last	C. Due to (or as d.	a consequenc	ce of):							
P.O. Box	es that the death certific igned by the ettending p be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetaf de	ath 3	Ectopic pregnand Other (specify)	y				Date of deliv Month	very Day Year
	quires that n signed b uld be deta	<u>م</u>	Part fl. Other significant conditions of	ontributing to death be	ut not resultin	ng in the u	nderlying cause gr	ven in Part I			bacco use c es 2□No		the cause of death?
Division of Vital Records,	The law requir ete has been si page 2 should l	Completed								24a. Was a autopoperfor	sy	prior to co death?	topsy findings available ompfetion of cause of
/ita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hannita':				h \		Check only or			
$\frac{1}{2}$	hysi this c	유	TUTES ZIANO	Hospital: 1 ☐ Inpatie	- 1		T 3L DOA			5 Resid			ıfy)
Ĕ	After unerg	u o	27. Manger of Death 1. Natural 5 ☐ Pending	28a. Date of Inju (Month, Da)	Year) 28	b. Time o fnjury	Wo			d. Describe h	ow infury oc	curred	
Sic	Attending r death. ector: After by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		.a. Athama]Yes 2 🗌		f Location /S	treet and No	imbor or Pu	ral Route Number,
Σ	or A efter Direct in by	Certification:	4 Homicide determined	building, etc	. (Specify)	r, raim, su	eet, factory, office		20	City or Tow		771067 01 7107	ar riodie remider,
	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page	ca	(Check only 2 Medical Evan	ysician: To the best of the basis of and manner sta	ovamination	and/or in	vectoration in my	oninion des	th occurred	at the time	date and place	on and dun!	to the course(a)
	o the	Me	29b. Signature and title of certifier				29c. Licen	se number		- 2	29d. Date sig	ned (Month	, Day, Year)
	->-0		> 5	(1) run			D	3060	41		Amil	145	200 6
	O,		30. Name and address of person who o	completed cause of d	eath (Item 23	a) (Type.	Print)		1	0 1	1/1/1	11	1
	Sta	ate_	29b. Signature and title of certifier 30. Name and address of person who of Rames L. S. hap a 31. Date filed (Month, Day, Year) APR 0 6 20	74 201-1 323Registr	109 Bar's Signature	ack	RIVEY Ne	ck Il.	000	Balt.	more	May	1 (and 21+21
	Regist	rar	APR 0 6 20	06 /200	1	100							

			1 - For State Registrar	State of Maryland		artment of H			giene	16 10706
	Physici	an	1. Decedent's Name (First, Middle, Last)	-				2. Date of Dea		3. Time of Death
	/Media	cal	John Sterling Fess 4a. Facility Name (If not institution, give st.			4b. City, Town, or	Location of Deat	1 1 1 1 1	4c. County	0. 0. 1
	Examir	ier	Baltimore Washingt		nter	Glen Bu				Arundel
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. /a	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	Birthplace (State or Foreign Country)
	Director		220-36-3108	^{M 2□ F} 67	Yrs.			12-18-	1938	PA
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	Mary I eh	to	MD Anne Arun	del Gle	n Bur	nie				1 ☐ Yes 2√2 No
	or 288	Funeral Director	10e. Street and Number			10f. Zip Code	***************************************		10g. Citizen of W	hat Country?
	23a (ral	1201 Kimberly Lane			21061			U.S.A.	
	er der	une	11. Marital States	2. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- American Indian, k, White, etc.
36	within 72 hours atter deeth with the Maryland ene. than 'natural', or iteme 23a or 28a-f ehow ha Madigal Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√€ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	white
9	2 hou	ted	15. Decedent's Educa	ition	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Bu	siness/Industry
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done o DO NOT use retired,)	rking		
21	73 75 75 75		To Entry to Alexander (Entry Alignet Land)	2	Outa	ge Coordi		(5: A A A A A A A A A A A A A A A A A A		lities
Maryland 21215-0036	D = D •	Be	17. Father's Name (First, Middle, Last) Sterling H. Fessle	r				me (First, Middle, eth Novok		9)
2	d 2 should the and Men 7 is marke treumatic	우	19a. Informant's Name/Relationship (Type		19b. Mailin	ng Address (Street a				State, Zip Code)
	12 a 7		Mrs. Muriel C. Fes	sler / wife	120	l Kimberl	y Lane;	Glen Bur	nie, MD	21061
Baltimore,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re	COL	ice of Dispo	sition (Name of matory or other place	θ)	Date	20c. Location -	City or Town, State
Ĕ	Pag ment ant: h		4 Donation 5 Other (Specify)	Mead		ge Memori			E1kridge	
Salt	permit. Pages 1 Department of H Important: If Ite eny injury or ot ance.		21. Signature of Funeral Service Licensee		- 1			_		Home, PA
	40304		23a. Part1. Exter the disease, or complic	neur Mol.		Second A				Approximate
760, <	death certificate be executed e attending physicien and d for use as the burial-transit	Icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseque	arice of).	lidney	can	ler		
.O. Box 68	death certific e attending pl d for use as t	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3[Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery th Day Year
۵.	The law requires that the tie has been signed by thoage 2 should be detache	by Pr	Part II. Other significant conditions conti	ributing to death but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contr	ibute to the cause of death?
Records,	w require been sig should b							1 🗆 Y	es 2 No	3 Probably 4 Unknown
ecc	e law re has be	Completed						24a. Was autop	sy p	Vere autopsy findings available rior to completion of cause of
<u>=</u>		Cou						perfor		eath? ☐ Yes 2☐ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	spital:		othe Othe	ar _	ath (Check only o		Allensia e di
o o	Phys this ral dii	To	1 ☐ Yes 2 No 27. Manner of De th	1 Sunpatient 2 Lie	R/Outpatier 28b. Time o	IL SUIDON	4 🗀 indising i	1ome 5 Resid	lence 6 Othe	
on	Attending I r death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		(? Yes 2 ∐No			
Division	Attendi ar death. ector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, tarm, st	eet, factory, office		28f. Location (S City or Tow	Street and Number	er or Rural Route Number,
	ital or A irs efter rei Directed in by	Cer							1112	
	To the Hospital or Attenwithin 24 hours efter deatl To the Funerel Director: completely filled in by the	edical		cian: To the best of my know er: On the basis of examination and manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, Day, Year)
	0		Hanto	m		7 4	3977		amil 6	7 2000
	10		30. Name and ddi ss of person who con	pleted cause of death (Item	23а) (Туре,	Print)			7	
	10		31. Date filed (Month, Day, Year)	11 403721 00	eur,	Wen 13	wme.	ms 2	eld,	
*	Sta Regist	ate rar	APR 0 6 2006	32. Registrar's Signatu	100	الم				

			1 - For State Registrar	State of M	Marylan	•			lealth and Death	Mental Hy	giene Reg. No.	06	10707
	Physici	an	Decedent's Name (First, Middle	•	as Alle	en Fox				2. Date of D Month	_{Day} April 3, 20	Year 06	3. Time of Death 3:06 a. M
	/Medic Examir		4a. Facility Name (If not institution					Town, or	Location of Dea			nty of Deat	h
	Exami			Gilchrist Hospic	e Cente	r				Towson		Ва	altimore
	Funeral	7	5. Social Security Number		Age (In yrs.	last birthday)	If Unde Months		If Under 24 Hrs Hours Min		rth ay, Year)	9. Birt	hplace (State or Foreign
	Director		218-74-4161 Usual Residence of Decedent	75W 2U F		49 Yrs.					9, 1957		Maryland
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	with the Maryland a or 28a-f ehow be notified at	ţō	Maryland	Howard				Е	Ilicott City				1 ☐ Yes 2 No
7	th the	irec	10e. Street and Number	, londid			10f. Zij	Code			10g. Citizen o	of What Co	ountry?
4	E 23	Funeral Director	8634 Bali Rd.						21043			U.	S.A.
0	iteme	Jue	11. Marital Status	12. Was Deceder Armed Force	s?	.S. 13. \	Was Dece f Yes, spe	dent of H	ispanic Origin? (n, Mexican, Pue	Specify Yes or N rto Rican, etc.)	o- 14. A	ace - Ame	ncan Indian, e, etc.
30 6 10036	s afte	by F	1 ☐ Never Married 2 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☐ If Yes, Give Year or Date:	•		1 🗆 Yes	2 No	Specify:		Spe	cify:	White
0306 215-0036	72 hours natural', alcal Ex	edt	15. Decedent		5.	16a. Deced	dent's Usu	at Occup	ation		16b. Kind of	Business/	Industry
o 215	nin 72 in "ni	plet	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4c	or 5+)	(Give	kind of wo	rk done d	turina most of wo	orking			ucation
212		Completed	Elementary/Secondary (0-12)	5+				Ar	Teacher				
3 4	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, I	ast)					18. Mother's Na	ime (First, Middle	a, Maiden Sum	ame)	
ع <mark>s</mark>	should be filed nd Mental Hygi marked other imatic event, I	2		arry Clay Fox							/iola Ande	-	
S at Maryland	2 2 2 3		19a. Informant's Name/Relationsh	nip (Type, Print)						lural Route Numi		m, State, Z	Zip Code)
~	9 8 8 9		Mrs. Joyce Fo	x W	/ife 20b. P	lace of Dispo			Efficott City	/, Maryland	21043 20c. Locatio	n - City or	Town State
\ 5 5	ages nt of t: # lt		1 Burial 2 ☐ Cremation			emetery, cren	natory or t	other plac	1//	7 W.			e, Maryland
1/3/01	permit. Pages 1 Department of H Important: # Ite eny injury or ot		4 Donation 5 Other (Sp. 21. SignAturis of Funeral Service I				Ridge		tery 17 (Suc	-	INCOVIII	e, maryiano
A BB	Per Jany Per Per Jany		Mountil	Dest to	itm	1222		Slack	Funeral Ho	me, P.A.	-4 Oit M	D 0404	•
			23a. Part1. Enter the disease or shock, or heart failure. List	complications that caus	ed the deat	h. Do not ent	er the mod	de of dyin	g, such as cardia	ia Pike Ellic ic or respiratory	arrest,	U 21U4	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		_	cell (Onset and Death
	/Medical		resulting in death)	d	as a conseq		0000						MINTO
	Examiner		Sequentially list conditions,	b									
/	sit ad	lue	d any, leading to inittlediate cause. Enter Underlying	Due to (or a	as a curseq	uerice of):							
0	te be executed ysiclen and te burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a conseq	uence of):							
760	ate be ex sysiclen he buria	calE											
				d								ĺ	
(p, r Box 68	law requires that the death certifical es been signed by the attending phy 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			1c				23d. I	Date of del	ivery
X B	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant	at time of d]Ectopic p] Other (s _i					Month	Day Year
0.	at the de by the a	hys	9 ☐ Unknown	9□ Unknown									
Ś	ires tha signed I	۵	Part II. Other significant condition	ns contributing to death	but not res	ulting in the ur	nderlying (cause give	en in Part I.				the cause of death?
×	w requii	ted		-						1	Yes 2□No	3 □ Pr	obably 4 Munknown
100	e law hes b	Completed								24a. Wa auto	psv	prior to d	topsy findings available completion of cause of
17/1	Th ete pag	ပ္ပိ								peri 1 ☐ Yes	ormed? 2.8 No	death?	2□ No
MAS on of Vita	Physician: Tribis certificel	Be	25. Was case referred to medical examiner?	Hospital:	_			Oth		ath (Check only			1
40	Phys this raldii	- 1 1	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpa		ER/Outpatien 28b. Time of				Home 5 ☐ Res	how injury occ		own hospice
M. no	Attending I r death. actor: After by the funer	ig	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, L	Day Year)	Injury	м	28c. Injun Worl 1 □ '	(? Yes 2 □ No	255. 2550, 25	non anjany coo	01100	
6 Visi	dea tor the	Certification;	3 ☐ Suicide 6 ☐ Could n	ot be One Place of	Injury - At ho	ome, farm, str	eet, factor			28f. Location	(Street and Nu	mber or Au	ıral Route Number,
一首	2 th 2 th 2	Sert	4 Homicide determine	building,	etc. (Specify	y)				City or To	wn, State)		
1	E T T E	edicai (29a. Certifier 1 Certifyin (Check only one)	g Physician: To the be- Examiner: On the basis and manner	of examina	wiedge, death tion and/or inv	n occurred vestigation	at the tin	ne, date and place pinion, death occ	e, and due to the curred at the time	cause(s) and date and plac	manner as e, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			·		c. License			29d. Date sig		
	->-0		> Alla	Mons				DSE	3303		April	3 2	2006
	20		30. Name and address of person v		of death (Item	n 23a) (Type,	Print)		2				
	20		AMON CHALL	es, m 660	1 0	. Cha	rus	1+	BACTIN	use m	21204	; 	
- 1	Sta Registr		31. Date filed (Month, Day, Year)	167	strar's Signa	iture	Se 3						

			1 - For State Registrar		epartment of Health and Certificate of Death		ene 0 0 6	10708
			1. Decedent's Name (First, Middle, Last)		0	2. Date of Death	Day Year	3. Time of Death
	Physicia /Medic		DIANE		GLEEN	MARCH	28, 2006	18:47 PM
	Examin		4a. Facility Name (If not institution, give str	eet and number)	4b. City, Town, or Location of Dea	ith	4c. County of Deat	n
			The Johns Ho	(King HOSPita)	Baltineners			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthe		s. 8. Date of Birth	9. Birtl	nplace (State or Foreign untry)
	Director		216-84-2978 10M	32 Yr	s. Months Days Hours Mir	1. (Month, Day,)	974	MD,
	D		Usual Residence of Decedent				/	
	ylan		10a. State 10b. County	10c. City, Town			-	10d. Inside City Limits
	Mar.	ţ	MD.	BALTIN	NORE			1 Yes 2 No
	r 282	rec	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	untry?
	3a o	9	1632 ASQUITH	57.	2/2/3		11.5	A
	ms 2	Funeral Director		. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Ame	
(0	r lte	Ē	1 Never Married 2 Married	1 ☐ Yes 2 M No		rto Rican, etc.)	Black, White	e, etc.
ဗ္ဗ	urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: 51	ACK
21215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Marical Examination of the multipled at	Completed	15. Decedent's Educa		ecedent's Usual Occupation	10	6b. Kind of Business/	ndustry
7	7 oic 7	ple	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done during most of w fe. DO NOT use retired)	orking		
7	d with	E	874	Conege (1-401-54)	FACTORY	/	TOUSEKE	EPING
	othe	Вес	17. Father's Name (First, Middle, Last)			ame (First, Middle, Ma	aiden Sumame)	
Maryland	d be senta	To B	JOHN WILLIAM G	REEN	1016	Ins B	ANISATI	1 LAYLANA
2	should nd Men marke	-	19a. Informant's Name/Relationship (Type		Mailing Address (Street and Number or F	Rural Route Number,	City or Town, State, Z	ip Code)
Š	lith a		ROCHELLE GOFF	W 23/	2 Akin ST. BA	TIMOREI	MD. 212	10
a)	1 ar Hea Hem		20a. Method of Disposition	20b. Place of C	isposition (Name of	-	0c. Location - City or	
altimore,	Pages nent of int: If it iry or c		1 Daurial 2 Cremation 3 Rer	noval from State	crematory or other place)	-0 01	Malts	MAN)
₫	it. Purtme	- 1	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 	WII.	22. Name and Address of Facility	0-04 1	Horfono Fu	End SEQUE
Ba	permit. Pages 1 and 2 should be tiled within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, It's Marical Experient mast be notified at once.		William August	1	011 01	- British		
			23a. Part 1. Enter the disease, or complica	tions that caused the death. Do no	2431 E, OLIVER ST	1 /SHLIUI	MD, 212	Approximate
			shock, or heart failure. List only one	cause on each line.	tonior the mode of dying, saery as sure	as or respiratory arros	, , , , , , , , , , , , , , , , , , ,	Interval Between Onset and Death
	Physician	8 9	Immediate Cause (Final disease or condition resulting in death)	respiratory	SULCE LINES ENS	1e1-		
	/Medical Examiner		Toolaing in docum	Due to (or as a consequence of	:			
		e.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of				
	ed sit	lhe	cause. Enter Underlying	Due to (or as a consequence or	•1 1. 5080 (500-00) //			
	and and I-trar	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a consequence of	thre dison	-		
8760,	cate be executed physician and the burial-transit	a E						
87	cate ohysi the l	dical	d .					
9		Me	IF FEMALE:	M				
Вох	death certifi e attending id for use as	an/	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of deli	very Day Year
0	the a	sic	1 ☐ Yes 2 ☐ No 9 XUnknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)			
<u>a.</u>	The law requires that the death certiful has been signed by the attending to be 2 should be detached for use as	Physician/Me		huting to dooth hut not condition in t	na vandashira savas avvas in Dart I	22a Did taba	acco use contribute to	the equal of death?
Ś	res tha igned be det	by	Part II. Other significant conditions contri	pouring to death but not resulting in t	ie underlying cause given in Part I.			_ /
Records,	w requir	ted				1 1 105	2 □ No 3 □ Pr	Stably 42 Miknown
e C	e law has b	ple				24a. Was an autopsy	prior to d	topsy findings available completion of cause of
<u> </u>		Completed				perform 1 ☐ Yes 2		2 No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?		26. Place of D	eath (Check only one)	
_	di is	To	1 ☑ Yes 2 ☐ No	spital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: 4 Nursing	Home 5 ☐ Residen	ice 6 Other (Spec	cify)
J Of			27. Manner of Death	28a. Date of Injury 28b. Tir (Month, Day Year) 1nji		28d. Describe how	v injury occurred	
<u>.</u>	Attending r death. ector: After by the fune	atlc	1 Natural 5 Pending 2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	Atto	tţ	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	s aft et DI ed in	Certification:		, (-,, ,				
	Hospitel or 44 hours afte Funerel Dir tely filled in I	cal			death occurred at the time, date and place investigation, in my opinion, death occ			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	ledical	one)	and manner stated.				` `
	To To	Σ	29b. Signature and title of certifier	<i>C</i> •	29c. License number		d. Date signed (Montl	n, Day, Year)
			- Inacu	thun M	D 000255	15	3/30/	o (
			30. Name and address of person, the com-	pleted cause of death (Item 23a) (T	(pe, Print)		1	
	1-27		100		OFF St. 104Hi	MORE, ILIC	1.2128	/
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		/		
	Registr	ar	APR 0 6 20	DE Property	Ann. H.			

DHMH 17 Rev 1/200

ORIGINAL

			1 - For State Registrar	State of Marylar				ealth a Death	and M		giene Reg. Na	000	0709	
	Physici /Medic		Decedent's Name (First, Middle, Last) Dolores	Agnes	1	Hesse				2. Date of De Month April		2006 Year	3. Time of Death 17:26P M	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Examir		4a. Facility Name (If not institution, give s Southern Maryland	Hospital			Clin					c. County of Death Prince Ge		
· ·	Funeral Director		5. Social Security Number 6. Sex 578-36-4282	7. Age (In yrs. 76	last birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bin (Month, Da APTIL C	th y, Year	9. Birthp 29 Washi	lace (State or Foreign htry) .ngton. DC	
	the Maryland r 28a-f show	rector	10a. State 10b. County Maryland Prince Geo 10e. Street and Number		restvi) Code				10g. Ci	itizen of What Coun	Od. Inside City Limits 1 Yes 2 No	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itame 23a or 28a-f show any injury or other traumatic event, If a Medical Examener must be confilled at once.	by Funeral Director	3603 Jaywood Avenue 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Dece	cify Cuba	spanic Orig n, Mexican Specify:	gin? (Spe Puerto l	ecify Yes or No Rican, etc.)	-	U.S.A. 14. Race - Americ Black, White, Specify: White	etc.	
Baltimore, Maryland 21215-0036	od within 72 hou giene. er then "natura i the Medical E	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th	cation		dent's Usu kind of wo DO NOT u maker	ork done d se retired	ation during most	t of workii	ng		ome	dustry	
yland	ould be file Mental Hy arked oth	To Be (17. Father's Name (First, Middle, Last) George Parke					A	gnes		Smi	th		
e, Mar	1 and 2 sh Health and em 27 is m		19a. Informant's Name/Relationship (Ty) Charles C. Hesse 20a. Method of Disposition	(Husband)	360 Place of Dispo	3 Jay	wood	Aven	ue F	orestvi	ille	or Town, State, Zip , Marylar .ocation - City or To	nd 20/4/	
3altimor	permit. Pages Department of Important: If it any injury or o		20a. Method of Disposition Commercial Com											
	Physician and physician and Examiner the prival-Iransit	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	cations that caused the deat le cause on each line. Acute my Due to (or as a consect	h. Do not ent O (V) juence of):	er the mod	de of dying	g, such as	cardiac o	r respiratory a			Approximate Interval Between Onset and Death	
O. Box 68760,	ath certifi ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregni 1 □Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	Ideath 3[⊒Ectopic p ⊒ Other (sø						23d. Date of delive Month	ory Day Year	
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying o	ause give	en in Part I.			obacco /es 2	use contribute to th	77	
I Reco	: The law re cate has bee page 2 sho	Completed	HYPER TENSIL	N						24a. Was autop perfo 1 Yes	an sy rmed? 2XXNo	prior to cor death?	psy findings available inpletion of cause of	
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ation; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending investigation	ospital: 1 □ Inpatient 2 ₹ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injury Work	91: 4 □ Nui	rsing Hor	n (Check only one 5 Residence 1986). Describe h	dence	6 □Other (Specify	/)	
Divis	tal or Atters as after des al Directored in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	ome, farm, str fy)	reet, factor	y, office		2	28f. Location (S City or Tox	Street ai	nd Number or Rura e)	l Route Number,		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical										the cause(s)		
		_	29b. Signature and title of certifier	moleted access of the W. Co.	226\7			033	1			ate signed (Month, I	•	
	\ \D	te.	30. Name and address of person who co TERM JOS RIE, M 31. Date filed (Month, Day, Year)	mpleted cause of death (Iter 7503 32. Registrar's Signary	SURR	ATTS	ROA	n, c	LINTO	c.v, MH	RYL	AND DOF	-35	
1 . S	Registr		APR 0 6 2006	Elegence H.	Bostle	P								

		riogisarei	Timodio or Dodin	ental Hygie Reg. 2. Date of Death	No. 3. Time of Death
Physici /Medi	cal	1. Decedent's Name (First, Middle, Last) ROBERT HENNIGAN 4a. Facility Name (If not institution, give street and number)		Month APRIL	Day Year 5, 2006 7:30 a ^M 4c. County of Death
Examir Funeral Director	ier	2244 W. FAYETTE STREET 5. 277 Security Number 6. Sex 7. Age (In yrs. last birthda) 7.	BALT IMORE // If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You	9. Birthplace (State or Foreign Country) SC
/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	1-16-1916	10d. Inside City Limits
death with the Maryland ms 23a or 28a-f show must be notified at	Director	MD BALTIMO	DRE 10f. Zip Code	100	1 ∑ Yes 2 ☐ No
3a or		2244 W.FAYETTE STREET	21223		USA
	by Funeral		. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
Z15-U	Completed	(Specify only highest grade completed) (Gin Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation le kind of work done during most of workin DO NOT use retired)	ng 16	BETHLEHEM STEEL
be filed tal Hygi of other event, I	Be	17. Father's Name (First, Middle, Last) ROBERT H. B. HENNIGAN	3UTLER 18. Mother's Name ANNA BAS		
re, Marylar s 1 and 2 should be t Health and Menta item 27 Is marked other treumatic or	2	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street and Number or Rural) S. MOUNT OLIVET LA		City or Town, State, Zip Code) FIMORE, MD 21229
re, N s 1 and : f Health item 27 other tr	-	20a. Method of Disposition 20b. Place of Disposition			c. Location - City or Town, State
Baltimore, Dernit. Pages 1 at Dep riment of Hea mpcriant: If item any injury or othe		1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON	PARK CEMETERY 4-1		BALTIMORE, MARYLAND
Baltimore, permit. Pages 1 and Deportment of Heall Important: If items any injury or other page.			22. Name and Address of Facility JAM. 1701-31 LAURENS ST.		RTON & SONS F.H., INC. ORE, MD 21217
cords, P.O. Box 68/60, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	23a. Part 1. After the disease, or complications that caused the death. Do not e shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	the cardiovaso		
Division of Vital Records, P.O. Box 68 To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as it.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Festal death 4 □ Pregnant at time of death 9 □ Unknown	B □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rdS, P, quires that a signed by uld be deta	ed by Pr	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death? 2 ऒNo 3 □ Probably 4 □Unknown
Vital Records, siclen: The law requires to certificate has been signe rector, page 2 should be c	Complete		7		No 1 Yes 2 No
VITS /siclen	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	26. Place of Death	11	ce 6 Other (Specify)
Division of a tending Physical death. Director: After this din by the funeral di		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		28d. Describe how	injury occurred
Division of Vital Rec To the Hospitel or Attending Physiclen: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
he Hospit n 24 hour he Funera pletely fills	Medical (29a. Certifier Certifying Physician: To the best of my knowledge, de (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	ed at the time, date	e and place, and due to the cause(s)
To t withi To t	Σ	29b. Signature and title of certified	29c. License number 29c. Vicense number	9	d. Date signed (Month, Day, Year)
7		30. Name an oress of person who completed cause of death (Item 23a) (Type M) Neg (100 D) A Usung M	pe, Print) 5/6 N. Rolli	ing Ad	Ballo hod 28
St Regis	tate trar	31. Date filed (Month, Day, Year) APR 0 6 2006	lade	,	

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

ORIGINAL

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

BALTIMORE

Date of Death Month

March

Day

31

Year

2006

4c. County of Death

N/A

9:50 a^M

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

HORTON

4a. Facility Name (If not institution, give street and number)

JOSEPH RICHIE HOSPICE

WOODROW

Funeral Director		5. Social Security Number 247-56-6778	6. Sex ÌŒM 2□		yrs. last birt		f Under 1 Year fonths Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D FEB 2	ay, Year			hplace (State or Foreign untry) TH CAROLINA
uryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City L									10d. Inside City Limits			
Ba-f	Director	MARYLAND N/	A		BAI	TIMO	RE							1 ⊠Yes 2 ☐ No
death with the Maryland ome 23a or 28a-f ehow if must be notified at		10e. Street and Number 10f. Zip Code 21216							10g. Citizen of What Country? U.S.A.					
r dea	Funeral	11. Marital Status	Armed Forces?			ver in U.S. 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto F					polify Yes or No- Rican, etc.) 14. Race - American Indi Black, White, etc.			
hours after turel', or Ite	þ	1 ☐ Never Married 2 🕻 Marri 3 ☐ Widowed 4 ☐ Divorced	1 Never Married 2 Married 1 Yes, Give 1 Year or Dates:			1 ☐ Yes 2 【X No Specify:						Specify	BI	LACK
72	Completed	(Specify only higher Elementary/Secondary (0-12)		eted) ege (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRANSCER DO THER								
THE R. P. LEWIS CO., LANSING, MICH.		6th grade	1 - 1		Г	TRUCK DRIVER								GARAGE
0000	To Be	17. Father's Name (First, Middle, RILEY HORTON						18. Mother's Name (First, Middle, Maiden St						
shoul nd Ma mart	F	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)								(ip Code)				
nd 2 lith ar 27 is r trau		Helen M. Hort	on/Wife				N. Long							
S 1 a 1 Head of the other		20a. Method of Disposition		2	Ob. Place of	Disposition		1		ate	,	<u> </u>		Town, State
Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S					IAL PAR	1	4-05	-06	BAI	TIMO	RE.	MARYLAND
permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic.		21. Signature Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HO 1206 W NORTH AVENUE												
		23a. Part1. Enter the disease, or	complications	that caused the	death. Do n	_					arrest,			Approximate
Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_ a L	len	g	Ca	ne	er	_					Interval Between Onset and Death
Examiner				ue to (or as a co	ona@quence o	r):								
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury												
be executed icien and burial-transit	Examiner	Cause Disease or injury Cause Disease or injury Intal initiated events resulting in death) Last Due to (or as a consequence of):												
e execution and urial-tran														
icate be physicial the bu	dlca		d									-		
eath certificate battending physical for use as the	/Me	IF FEMALE:	23c. If ve	s, outcome of p	regnancy							23d. Dat	o of doli	von.
the d	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown							Month Day Year				
s that if	by Ph	Part II. Dther significant condition	ons contributing	to death but n	ot resulting in	the unde	rlying cause give	en in Part I.		23e. Did	tobacco	use contr	ribute to	the cause of death?
requires	eted b								1 Yes 2 No 3 Probably 4 Unknow				obably 4 Unknown	
5 A 16	Be Complete									24a. Was		24b. V	Vere au	topsy findings available completion of cause of
Ician: The law certificate has I ector, page 2 s										perf	ormed? 2 N	1 0	leath?	2 No
cian: ertific		25. Was case referred to medica examiner?							of Death	(Check only	one)			1/
hysla this call dire	မ	1 ☐ Yes 2 XNo	Hospital:	1 Inpatient	2 ER/Out		3□ DOA Othe	4 🗆 190		ne 5□Res		6 Oth		IN HOSPICE
Attending Physician: r death. sctor: After this certific by the funeral director,	atlon:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	gation	Date of Injury (Month, Day Ye	28b. T	ime of jury	M 28c. Injury Work	rat ∢? Yes 2 🔲		28d. Describe	how inju	ury occurr	ed	
al or Att	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						8f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										stated. to the cause(s)		
To the To the comp		29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon							(Month	Dey, Year)				
1.		30. Name and address of person	who completed	I cause of death	(Item 23a) (Type, Prij	nt)			2		10	//	
V		MARREL L.H	DROWI	-51	1425	B	OLTON	Se	, 1	DALT,	ME	RE	-/	1) 2/2/7
Sta		31. Date filed (Month, Day, Year)	-	32. Poistrar's	Signature				7					<u> </u>
Registi	ar	APR 0	6 2006	Blown	. K	A STATE OF THE PARTY OF THE PAR	Wed .							

DHMH 17 Rev 1/2001

			For State Registrar	5	State o	f Mary			ırtmen	t of H		and M	lental l		ene	06	107	enterprise
	Dhusiai		1. Decedent's Name (First, Midd								·		2. Date of Month		Day	Year	3. Time o	
	Physici /Medic			Jones									April	4,				0 P ^M
	Examin	er	4a. Fecility Name (If not institution	-					-		r Location	of Death				ity of Death		
			Gilchrist Cente 5. Social Security Number	6. Sex	HOS	7. Age (In	ure last	highday	TOWS		If Under	24 Hrs.	B Date of	Righ				or Foreign
	Funeral Director		509-54-6540		1 2□F	7. Age (m		Yrs.	Months	Days	Hours	Min.	8. Date of (Month) Aug.	7ay.	949	Kans	place (State on Intry) as	or r oreign
			Usual Residence of Decedent								1							
	rylan show		10a. State 10b. Count			100	c. City, To	own or Loc	cation								10d. Inside C	-
=	h the Marylan or 28a-f ehow coolified at	5	Maryland Balti	more			Esse	X	_									2 €M0
F. M	with th	Funeral Director	10e. Street and Number						10f. Zip						_	f What Cou	intry?	
	ss 23a	era	1302 Old Easter			edent Ever	in IIS	13 V		221	lisnanic Or	inin? (Sn	ecify Yes o		U.S.A	ace - Ameri	ican Indian	
00	fter dea	Ē	11. Marital Status 1 □ Never Married 2 □ Ma		Armed Fo	rces?		If					ecify Yes or Rican, etc.)		lack, White		
036	2 hours after death with atural; or items 23a or	Ď.	3 ☐ Widowed 4 ☑Divorce	d	Pres, Giv Year or D	2□No /e ates: Vie	etna	m 1	☐ Yes	No	Specify:	•			Spec	ify: Wh	ite	
%; 5-0036	within 72 hours after death with the Maryland ane. then "natural", or items 23s or 28s-f show "s Medical Evant, or must be notified at	Completed	15. Decede (Specify only high				11	6a. Deced	ent's Usua kind of wo	al Occup	ation during mos	st of work	ing	1	6b. Kind of	Business/Ir	ndustry	
2121	within ne.	ğ	Elementary/Secondary (0-12)	Ť	College (1	1-4or 5+)	F	irefi irefi			d) -				City	Gover	nmont	
2	il Hygien Other th		12 17. Father's Name (First, Middle	(ast)			I.	TIGII	.girce	_	18 Moth	er's Name	e (First, Mic				IIIICIIC	
and	d be f antal h	Be	Maurice H. Jone										/ Lewi					
2006 Maryland	2 should be to and Mental I is marked o raumatic eve	ြ	19a. Informant's Name/Relation		, Print)		1	19b. Mailin	g Address				al Route Nu		City or Tow	m, State, Zi	p Code)	
S. Ma	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other then or other traumatic event, the Ms.		James Guy Jones	s (Bro	other)		8707	East	Wal	ton A	Avenu	æ, Sp	oka	ne, W	ashin	gton 9	9212
altimore,	es 1 and 2 of Health of Item 27 tr other tre		20a. Method of Disposition	a 🗆 🗆		2	0b. Place	e of Dispos etery, crem	sition (Nar	ne of ther plac	ce)		Date	2	0c. Location	n - City or T	own, State	
7 <u>E</u>	Page nent ant: If ury o		★★ Burial 2 Cremation 4 Donation 5 Other (Specify)	noval from							April	25,2	2006	Ft.	Myer,	Virgi	nia
Baltin	permit. Pages Department of Important: If i any injury or gives.		21. Signature of Funeral Service	Licensee	\geq			22	. Name an	d Addre	uzdzi	İnski	. Fune	ral	Home	, P.A	• 100000	8010-895
	202 = 9	<	1407 Old Eastern Avenue, Essex, Maryland 21221															
•	Physician /Medical Examiner		shock or heart failure. List only one cause on each line. Immediate Cause (Final disease) or condition resulting in death) a. Due to (or as a consequence of):										tween Death					
()	be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.		(or as a co												
3760	m > m	cai		d														
P.O. Box 68	Attending Physician: The law requires that the death certificate cleath. •ctor: After this certificate hes been signed by the ettending phy the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	230	1 Live t	tcome of pr birth 2 nant at time own	Fetal de	ath 3	Ectopic pr		/					Date of delive	*	Year
ds, P.	signed by	d by Ph	Part II. Other significant condit	ions contri	buting to d	eath but no	ot resultin	ng in the ur	nderlying o	ause giv	en in Part	ŧ.		oid tob	_W		the cause of	
Leura Vital Records,	ne law requir hes been si ge 2 should l	Completed									-		24a. V	Vas ar utopsy perform		o. Were aut prior to co death?	opsy findings ompletion of c	available cause of
7 E	ilcian: The lav certificate hes rector, page 2		25. Was case referred to medic	al al			-				OC Dies	a of Doct	1 Ye			1 🗆 Yes	2□ No	
	ysician: is certific director,	To Be	examiner?		spital:	Inpatient	2∏ER/	/Outpatien	t 3 🗆 DO	A Oth			h <i>iCheck</i> o. ome 5⊟ F			Other (Spec	n has	0/10
So uoi	ttending Phys death. ctor: After this y the funeral di		27. Manner of Death 1 ☑ Natural 5 ☐ Pend		28a. Date	F	28	b. Time of Injury		8c. Injur Wor	y at		28d. Descr				<i>""</i> 1400	pre
Division	al or Attend s after death at Director:	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be mined	28e. Place build	of Injury - ing, etc. (S	At home Specify)	, farm, stre	eet, factor	y, office					et and Nui State)	mber or Rui	al Route Nun	nber,
,	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by the	Medicai (29a. Certifier Check only 2 Medica	ing Physic I Examine	r: On the b	e best of my asis of exa ner stated.	mination	dge, death and/or inv	occurred estigation	at the tir , in my o	me, date <i>a</i> opinion, de	nd place, ath occur	and due to red at the ti	the ca me, da	use(s) and te and plac	manner as e, and due	stated. to the cause(s)
	withi Tot	Σ	29b. Signature and title of certifier					29c. License number 29d. Date signed (Month, Day, Year April 5 2006) (Item 23a) (Type, Print) (Item 23a) (Type, Print) (Item 23a) (Type, Print)						06				
_	4X1		30. Name and address of perso	wlls	w	1 (01	601	11.50	Print	Nes	2+	B1	rram	14	wo	21204	>	
	Sta Regista		31. Date filed (Month, Day, Yea	_	JUL 1	Registrar's	Signature	A STATE OF THE PARTY OF THE PAR										

Division of Vital Records,

After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Director:

> State Registrar

DHMH 17 Rev 1/2001

OCME 10/2003

2

Medical

3

Accident

Suicide

29b. Signature and title of certifier

4 V Homicide

Ling Li, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Pending

Could not be

as

Investigation

determined

(Specify) Street

and manner stated

mos



28e. Place of Injury - At home, farm, street, factory, office building, etc.

29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as started.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

or Town, State) 4711 Harford Rd , Baltimore, MD

April 4, 2006

		State of Maryland / Department State of Maryland / Certification	ent of Health and Mate of Death	Re	g. No. UU b	10716						
Physic		1. Decedent's Name (First, Middle, Last) Mary Anna Kight		2. Date of Death Month March	Day Year 31 2006	3. Time of Death 11:30PM M						
/Med Exami	ner	1267 Nursery Manor Drive F	ity, Town, or Location of Death 'in!TG ¹ DUYC der 1 Year If Under 24 Hrs. hs Days Hours Min.	8. Date of Birth (Month, Day, May 4, 1		h Brroll pplace (State or Foreign untry) Vland						
Director		Usual Residence of Decedent		2 0 7 10		10d. Inside City Limits						
with the Marylar 3a or 28a-f show	JO.	Total State		1 ☐ Yes 2 型 No								
	i Director		Finksburg Zip Code 21048	10	Og. Citizen of What Co	untry?						
JSD us after death us after death if, or Items 23	by Funeral	1 Never Married 2 Married 1 Yes 2 TNO	ecedent of Hispanic Origin? (Spispecify Cuban, Mexican, Puerto s 2🖾 No Specify:	ecity Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Win	e, etc.						
BAITIMOYE, MATYIANG ZIZIO-UUSO permit. Peges 1 and 2 should be filed within 72 hours alter death with the Maryland Depertment of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or Items 23e or 28e-f show important: If tem 27 is marked other than "natural", or Items 23e or 28e-f show important: If the Trium of the recities of an one.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SRIESO	i work done during most of worki Tuse retired)	ing	6b. Kind of Business/Industry Retail Sales							
	S	6 Sales 2	(First, Middle, Maiden Surname)									
	To Be	John Kight	Auvil									
ary 2 shou and M is mar	-				oute Number, City or Town, State, Zip Code)							
Baltimore, M Depermit. Peges 1 and 3 Deperment of Health Important: If Item 27 any injury or other tr		Mr. Lindsay Taylor, Jr., Son 1267 Nursery Manor Drive Finksburg, Naryland 20a. Method of Disposition 3 Removal from State 120b. Place of Disposition (Name of cemetery, crematory or other place) 12 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Lake View Memorial Fark 4/5/2006 Sykesville, Mary:										
Baltir permit. P Depertme importan eny injur	i kin	21. Signature of Funeral Service Licensee Parameter of Funeral Home & Chapel P.O.Box 195 Sykesville, Maryland 21784										
(8760, cate be executed Whedica end in the burial-transit	L.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
. Box 6 death certifi e attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectop 4 Pregnant at time of death 5 Other 9 Unknown 1 Unknown 2 The pregnant 2 The pregnancy 3	23d. Date of delivery Month Day Year									
ords, P.O requires that the seen signed by th hould be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying		23e. Did tobacco use contribute to the cause of a 1 Yes 2 No 3 Probably 4								
Pec e law has t	Completed			24a. Was a autops perform	y prior to med? death?	utopsy findings available completion of cause of s						
ion of ading Physath.	Be	25. Was case referred to medical examiner? Hospital: 4 Jessiest 2 EB/Outpatient 3	Other	th (Check on on		16-1						
	tion: To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) Injury M. M. M.	me 5 Residence 6 ⊡Other (Specify) 28d. Describe how injury occurred									
	Certification:	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or R City or Town, State)										
DIVIS To the Hospitel or Atte within 24 hours after dee To the Funerel Directo completely filled in by th	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occur (Check only one) Certifying Physician: To the best of my knowledge, death occur (Check only one) Certifying Physician: To the best of my knowledge, death occur (Check only one)	irred at the time, date and place, ation, in my opinion, death occur	rred at the time, d	ate and place, and du	e to the cause(s)						
To th withir To th	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 15/2006										
4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	54 Parl P1	Balt	timore 3	21202						
	State strar	31. Date filed (Month, Day, Year) APR 0 6 2006	,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#30, perIVR, (854, 4/6/ to II State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 0228 AM **Physician** 05 2006 Kunst Mildred /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Columbia **Howard County General Hospital** ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** 1□M 20F Director 214-14-1783 August 27, 1921 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Columbia Maryland Howard 10g, Citizen of What Country? 10f Zin Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Importent: If I fem 27 is marked other than "--- any injury or other traumest." 5 21046 U.S.A Items 23a 9906 Evergreen Ave. Completed by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 NO 1□Yes 2X No Specify: White 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Self Employed Elementary/Secondary (0-12) College (1-4or 5+) **Business Owner** 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hattie Mae Maddox ဥ Henry Glensky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9906 Evergreen Ave. Columbia, Maryland 21046 Mr. Victor W. Kunst, Sr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

1/☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/10/2006 Marriottsville, Maryland Crest Lawn Memorial Gardens
22, Name and Address of Facility 21. Signatifie of Funeral Service Liver see Slack Funeral Home, P.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y. MD 21043 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myscardial Interestron **Physician** /Medical Due to (or as a consequence of): Examiner Gastrointestura Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai Examiner g physicien and as the burial-transit The law requires that the death certificate be executed Viral Grastroer Due to (or as a consequence of): IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown þ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 s autopsy has 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No certificate To the Hospital or Attending Physicien: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 X No ۵ this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of fnjury 28b. Time of 27. Manner of Death Certification: After (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Homicide within 24 hours a To the Funerel E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2006 D005 +1 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 6 2006

Columbia, MD

Evan Allen English Howard County General Hospital, ate filed (Month, Day, Year)

APR 0 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year 22:35 PM FSHITS BERTA MARCH 2006 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE HOSPITAL RANDALLSTOWN NORTHWEST If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) NOV . 28, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□M 2ŪF UKRAINE Yrs. 91 215-35-3211 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No REISTERSTOWN BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21136 416 HIGHMEADOW ROAD 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married WHITE 1 ☐ Yes 2 No Specify: 3 N Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (UNKNOWN) **SPFKTR** TUBA MENACHEM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARINA LIVSHIN / DAUGHTER-IN-LAW 416 HIGHMEADOW ROAD - REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State CHIZUK AMUNO ARLINGTON 4/2/2006 BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HEART CONGESTIVE disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23d Date of delivery eath 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages Department of I Important: If it any injury or o

Physician

/Medical

Examiner

Funeral

Director

ral, or items 23a or 28a-f show Exemples must be notified at

Pages 1 and 2 should be titled within 72 hours after vinen of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or itee

traumatic event, If a Madical

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

2

the Maryland

Physician/Medical has After this death. the within 24 hours after deati To the Funaral Diractor: filled in by

þ

Completed

Be

Certification: To

Medical

or Attending Physician: The law requires that the death certificate be executed

the

Division of Vital Records, P.O. Box 68760,

	d
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown

art II. Other	significant conditions	contributing to death	but not resulting in	the underlying cause	given in Part I
END	STAGE	RENAL	DISEA	SE	

5. Was case referred to medical				26. Place of Death
examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatient	3□ DOA	Other: 4 Nursing Ho

h (Check only one) ome 5 Residence 6 Other (Specify) 2 ER/Outpatient 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of

051722

2 Accident	investigation	M	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	fie

28a. Date of Injury (Month, Day Year)

☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

one)	2 modicar E		nd mann
29b. Signature and	itle of certifier		
	Y	(0	

5 Pending

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. asis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

RANDALLSTOWN MD 21133

2 No

1 Yes

	1		م					M.	12.	
30	Name and	address of	person	who	completed	cause of	death	(Item	23a) (Type,	Print

MARCH 31 2006

	LEONARD RICHARDSON M	1.0. 5401
State	31. Date filed (Month, Day, Year)	32. Pagistrar's S
Registrar	APR 0 6 2006	1 2 40

29a. Certifie

27. Manner of Death 1 Natural

> gistrar's Signature APR 0 6 2006



State of Maryland / Department of Health and Mental Hygien 1 = For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 0904 02 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Oay, Year) 2/14/1924 Birthplace (State or Foreign Country) **Funeral** 1 M 25E Yrs. **Director** 82 217-12-5469 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d, Inside City Limits traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2X No Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Itame 23a 103 Claiborne Road 21037 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ita may injury or other traumatic event, If a Medical Examina 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No δ Specify: white 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Binder Printing Press 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas William Faulkner Rose Estowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Edward J. Lechert, Jr./son 103 Claiborne Road; Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vets. Cem. 14/6/2006 Crownsville, MD 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) -10D /Medical Examiner 24C Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (of as a consequence of) P.O. Box 68760, Physician/Medicai ass attending I IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending Within 24 hours after death.

To the Funeral Director: Af death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai ro the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number Name and address of person with use of death (Item 23a) (Type, Print) DEFENSE HIGHWAY ANNAPORD MY U 31 Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar APR 0 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1050 PM **Physician** 06 JON TE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE. RICHEY HOSPICE mD JOSEPH 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 10 M 2□F 214-08-5571 6/10/1978 Director MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show 1A Yes 2 □ No MD Director ALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 is marked other then "naturel", or items 23s or traumatic event, the Medical Exertity of this Let 3 / 3 3 4

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. LAKE WOOD by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BALTO, CITY SPRING LIVING CLASS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental HERBERT VERNETTA COSTIN ၉ MELVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Heelth a Important: If item 27 is any injury or other trat once. 426 BALTO, MD. 21224 MELVIN H. LYLE N, LAKEWOOD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State ARMEL CEMETERY 4/6/06 BALTIMORE MD
22. Name and Address of Facility PHILLIP A. WEATHERFORD FUNERAL SERV 4 ☐ Donation 5 ☐ Other (Specify) CARMEL CEMETERY 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2431 E, OLIVERST, BALTO. MD 21213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AIDS Physician MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be ex P.O. Box 68760 by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown To Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2X No 1 Yes Vital 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Division of 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c, Injury at Work? Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C 29a. Certifier 1 Certifying Physici n: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Registrar's Signature 31. Date filed (Month, Day, Year) APR 0 6 2006 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #1 Per Shate of Waryland Department of Health and Mental Hygiene State State Amend Item 1 per Dr., G854, Oct Oct Oct Death of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Francisco Laporte Month Year LAPORTE **Physician** 2006 Francisco LaPorte /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel ff Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 1 - 01 - 1 9 19 Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 1⊠M 2□F Yrs. Director 581-68-7646 86 1919 | Puerto Rico Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show or ser must be notified at MD Anne Arundel 1 ☐ Yes 2 No Severn Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Denson Drive 21144 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö If Yes, Give Year or Dates: 160-82 1 Yes 2 No Specify: puerto rican Specify: þ white 3 □XWidowed 4 □ Divorced natural Completed unk | 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) military unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Menta Camillo Diaz 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health lem 27 Department of Heat, important: If item 27 any injury or other gage. Angel Torres/brother HC 02 Box 4066 Guayama, Puerto Rico 00787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from/State 4 □Donation 5 ☑Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald & Wade State Anatomy Board 655 W. Baltimore Street reve Ull Baltimore, MD 21201 3a. Part1 Enter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERTEN **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a sunsequence of) Examine The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending pr IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy performed 2 1 No 1 ☐ Yes 2 🗹 No Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Matural 5 Pending r death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical (Check only ş 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number undligkun pm D 54574 3,27,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARKKIM 1412 NORTH ERAIN HWY GA GLENBURNIE, MD 21061 MO 31. Date filed (Month, Day, Year) APR 0 6 2006 32. Registrar's Signature State Registrar

			_ For	i icacc	State of	Marylar						ntal Hyg	jiene	nnc	10700	j
			1 - State Registrar				Cei	rtificat	e of L	Death			leg. No.	000	10166	
	Physici	an	Decedent's Name (F	irst, Middle, La	st)	×					2	. Date of Dea Month	th Day	Year	3. Time of Death	
	/Media	al	4a. Fecility Name VI no.			(3)		4h City	Town or	Location o	f Death	2	45 (County of Dea		л ——
	Examir	er	CV 1 -1	1		ale		46. City,	10WH, 01	2002	W		1 ()	More	(1./	
	Funeral		5. Social Security Number	1717	ex () 7	Age (In yrs.	last birthday)		r 1 Year	If Under 2		. Date of Birth (Month, Day	-	9. 8ir	thplace (State or Foreig	 gn
	Director		033-16-9019	9 1	□M 2 X F	82	Yrs.	Months	Days	Hours	Min.	oct 2 ,	1923		sachusetts	
	pg ,		Usual Residence of De 10a. State 10	cedent b. County		10c Ci	ty, Town or Lo	cation							10d. Inside City Limits	-
	faryla aho	ŏ	MD	Baltim	oro	100. 01	Caton		•						1 ☐ Yes 2√ No	
	28a-1	Director	10e. Street and Numbe				Caton		Code	-			10a Citiz	en of What C		_
	3a or		709 Maide		e Lane					228				USA	,	
	me 2	era	11. Marital Status	n onore	12. Was Deced Armed Force	ent Ever in U	.S. 13.	Was Dece			jin? (Speci	fy Yes or No- can, etc.)	1	4. Race - Ame		
ဖွ	or its	Ē	1 Never Married	_	1 Tes 2	X No	1	irres,spe 1 □ Yes		Specify:	, Pueno M	can, etc.)		Black, Whi		
8	within 72 hours after death with the Maryland ene. than "netural", or iteme 23a or 28a-f ahow tha Medical Examinar must be notified at	Completed by Funeral	3 ₩ Widowed 4 □		Year or Date	es:								Specify: W		
21215-0036	n 72 n	iete		Decedent's Econly highest gra			16a. Deced	dent's Usu kind of wo DO NOT u	ork done d	luring most	of working		16b. Kin	d of Business	/Industry	
7	withii then	шc	Elementary/Seconda 1.2	ry (0-12)	College (1-4 5+			ache					9.0	ducatio	n n	
0	Hygie other	BeC	17. Father's Name (Firs	st, Middle, Last)					4440 T- T	18. Mothe	r's Name (First, Middle,			11	
<u>lan</u>	uld be Aental rked c	To B								Gertr	ude E	velyn	Flow	er		
Maryland	2 should and Men is marks sumatic		19a. Informant's Name	/Relationship (Type, Print)									Town, State,	Zip Code)	
	and sealth m 27		Susan Bodi		ghter	1				eet A		ton, V		2205		
nore	Pages 1 nent of H int: If ita		20a. Method of Disposit	remation 3			Place of Dispo cemetery, cren	natory or o	me of other place	9)	Dai	9	20c. Loc	ation - City or	Town, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic avant, the Medical Examination must be collined at ance.		4 Donation 5 C 21. Signature of Funera Ron			wecto:	r St	2. Name ar	d Addres	s of Facility	Sard (655 W.	Bal:	timore	Street	
	20529		rena	1/1/	AXMI		Ва	1time	ore,	MD 2	21201					
	Physician		23a. Part1. Enter the d shack, or heart fa Immediate Cause (Final disease or condition	ilure. List only	one cause on eac	ised the deal th line.	(.)	4		,	cardiac or i	Λ	rest, ISES	<u>.</u>	Approximate Interval Between Onset and Death	
	/Medical		resulting in death)	-	Due to (or	as a consec						1				_
	Examiner		Secuentially list conditi if any, leading to imme	ions	b											
	nsit	Examiner	Cause (Disease or inju	19		as a consec	quence of):									
ó	te be executed ysicien and le burial-transit	Exa	that initiated events resulting in death) Last		Due to (or	as a consec	quence of):									
	ate be nysicié he bu	ical			. d.											
68	artifica ing ph e as t	Med	IF FEMALE:			-										
BO BO	ath ce	ian/	23b. Was decedent pre in the past 12 mor			h 2 ☐ Feta	al déath 3□	Ectopic p					2	3d. Date of de Month	livery Day Year	
P.O. Box	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	0	4 □ Pregnar 9 □ Unknow	nt at time of o	ieath 5	Other (s	овспу)							
رپ ت	ires that the death certificate be executed signed by the attending physicien and doe detached for use as the burial-transit	by Physician/Med	Part II. Other significar	nt conditions o	ontributing to dea	th but not res	sulting in the u	nderlying (cause give	n in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?	
ğ	w require been sig should b											1 🗆 Y	es 2□]No 3□P	robably 4 □Unknown	n
ဒ္ဓင	Attanding Physician: The law requires that the death certifica rideeth. rideeth. ector: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	Completed										24a. Was a autops perfor	sy	24b. Were an prior to death?	utopsy findings available completion of cause of	0
a	ding Physician: The lav h. After this certificate has funeral director, page 2											1 Yes	2 N o		2 □ No	
5	sicial s certi	o Be	25. Was case referred examiner? 1 ☐ Yes 2 ₺ No	to medical	Hospital: 1 □ lng	ationt 2	ER/Outpatien	nt 3 🗆 D0	Othe	-		Check only or		☐Other (Spe		
ō	g Phy erthis eral d	n: To	27. Manner of Death		28a. Date of	Injury	28b. Time of		28c. Injury	at		d. Describe h			icity)	
0	inding eth. ie fun	atio	2 Accident	☐ Pending investigation	1	Day Year)	Injury	М	Work 1 □ Y	res 2□N	No					
	or Atta after de Directo in by th	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	286. Place 0	f Injury - At h j, etc. <i>(Speci</i>	ome, farm, str	eet, factor	y, office		28	f. Location (S City or Tow		Number or R	ural Route Number,	- 1
_	To the Hospital or Attendwithin 24 hours after deets To the Funeral Director: completely filled in by the	edicai C	(Check only 2	Certifying Ph Medical Exam	ysician: To the b	is of examina	owledge, death	h occurred vestigation	at the tim	e, date and pinion, deat	d place, an	d due to the c	ause(s) a	and manner a	s stated. e to the cause(s)	
	To the Vithin 2 To the Complet	Med	one) 29b. Signature and title		and manne	r stated.			c. License					signed (Mon		
	⊢≱⊢ŏ		•	10	(M)						+>					
			30. Name and ddress	of person who	V	of death (Iter	η 23a) (Type.	Print)			1.1.	, , , , , ,	. 1	ch 30	,	
_			30. Name and Iddress	,					(91	W.	C914	1> 1/10	V	4/1		
	Sta Registr		31. Date filed (Month, L	Oay, Year)	06 Rec	gistrar's Sign	ture	A COLOR								

			1 - For State Registrar	State of	Marylar		artmen rtificat			and M	lental Hy	gien	UUU	07	23
	Dhunini		1. Decedent's Name (First, Middle, L								2. Date of De	eath Da	W Year	3. Time o	of Death
	Physici /Medio		Carol,	McCLea	RY						04	05		10:0	00 A ^M
	Examir		4a. Facility Name (If not institution, g	ive street and numb	ber)		4b. City,	Town, or	Location o	of Death		40	. County of Dea		
			Lorien Nursing C		ehab			timo							
	Funeral		1 12	Sex 7 1 ☐ M 2 ☑ F	. Age (In yrs.		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Bir (Month, Da	av. Year	9. Bi	thplace (State ountry)	or Foreign
l.	Director		216-34-3971 Usual Residence of Decedent		72	Yrs.					March	17,1	934 Per	nsylvar	nia
	land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	City Limits
	Mary f sho	ō	Maryland Baltimon	re	Not	tingha	m								s 2 XX 0
	28a	rec	10e. Street and Number		1100		10f. Zip	Code				10g. Ci	tizen of What C	ountry?	
	3a ol	iDi	4117 Baker Lane					2123	6				S.A.	· · · · · · · · · · · · · · · · · · ·	
	death ms 2	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U	.S. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Sp	ecify Yes or No Rican, etc.)	o- T	14. Race - Am	erican Indian,	
9	after or Ite	F	1 Never Married 2000 Married	Armed Forc 1 ☐ Yes 2 If Yes, Give		1				, Puerto	Rican, etc.)		Black, Whi	te, etc.	
93	ours iral',	d by	3 Widowed 4 Divorced	Year or Date	es:		1 🗆 Yes	2X_XNO	Specify:				Specify: W	hite	
5-	72 h "natu	Completed	15. Decedent's (Specify only highest g	Education rade completed)		16a. Dece	dent's Usua kind of wo	al Occupa nk done d	ation <i>luring m</i> ost)	of work	ing	16b. K	and of Business	/Industry	
12	within nne. han	mpi	Elementary/Secondary (0-12)	College (1-4	lor 5+)			se retired,)			Or	TIONS		
2	iled y tygie ther t		12 17. Father's Name (First, Middle, Las	*)		Homem	aker		10 Maha	-l- N	/Fina Adidate	1	n Home		
and	d be i	Be C	Percy Edgar Palme								e (First, Middle zabeth				
<u> </u>	should Me mark mati	우	19a. Informant's Name/Relationship			19b Mailir	na Address	(Street a					or Town, State,	Zin Codel	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Eractic errust for ricilized at once.		Bonnie Wittstadt		r)								land 21		
re,	S 1 a f Hea item othe		20a. Method of Disposition			lace of Dispo emetery, crer	sition (Nan	ne of	a)		Date	20c. L	ocation - City or	Town, State	
E	Page sent o nt: If ry or		1 ☐ Burial 2XX remation 3 `4 ☐ Donation 5 ☐ Other (Spec		ate	•	-		-	\pri	1 6.200	6 Ba	ltimore	. Mary]	Land
aĦ	mit. partn ports ports y inju		21. Someture of Funeral Service Lice	ensee	, _					_	11.0				
<u>m</u>	88 20 2	0	L'ESE		_	-	1407	olg	Easte	rn A	Avenue,	Ess	lome, P. ex, Mar	yland 2	21221
	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or conshock or heart failure. List only immediate Cause (Final disease or condition resulting in death)	aEN	th line.	MALO	er the mod			cardiac (or respiratory a	rrest,		Approxima Interval Bei Onset and	tween
	ed isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause iDisease of injury	b. Due to (or	as a conseq	uence of):									
oʻ	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or	as a conseq	uence of):									
8760,	ate be hysici the bu	dicai		d											
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		n 2 ∏ Fetal it at time of de	death 3	Ectopic pro						23d. Date of de Month		Year
ds, P	ires that signed b		Part II. Other significant conditions	contributing to deat	h but not resi	ulting in the ur	nderlying ca	ause give	n in Part I.			obacco (Yes 2	use contribute to		death?
Record	w require been si	etec									-				
Vital Red		Completed	25. Was case referred to medical	T					00 81		1 Yes	osy ormed? 2 No	prior to death?	topsy findings completion of c	available ause of
	ysician: is certific director,	o Be	examiner?	Hospital: 1Inp	ationt 2	ER/Outpatien	t 3 DQ	Othe	r /		(Check only o		6 - Other (One	- (6.)	1.57
o	ng Phy ter thii	\vdash	27. Manner of Death	28a. Date of	njury	28b. Time of		8c. Injury	at	-	28d. Describe I		6 □Other (Spe y occurred	спу)	
0	nding I th. : After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	Injury	М	Work 1 □ Y	? ′es 2 □ N	10					
Division of	Attendi er death. ector: A by the fu	ifica	3 Suicide 6 Could not determined	28e. Place of	Injury - At ho	me, farm, stre	et, factory	, office					d Number or Ri	ural Route Num	ber,
	ospital or Attendents after deatlenders Director:	Certification;	4 Homicide	building	, etc. (Specify	")					City or Tov	wn, State)		
	T 4 11 0	edicai	29a. Certifier 4 Certifying P (Check only one) 2 Medical Exa	hysician: To the be miner: On the basi and manner	s or examınaı	wiedge, death ion and/or inv	occurred a restigation,	at the time in my op	e, date and inion, deatl	place, a	and due to the ed at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s	;)
	To the I	Me	29b. Signature and title of certifier				29c	. License	number			29d. Dai	te signed (Mont	h, Day, Year)	
			Max MD					DJ	77	27	-	41	6/06		
	1)		30. Name and address of person who	completed cause	of death (Item	23a) (Type, I	Print) //		^		, 11		-		
	V\		Namalu Blo	way.	2- N	1ashe	A PL	all	- 'D	and	Wilk	M	1D 2	1275	
	Sta Registra		APR 0 6 2	32 Reg	istrar's Signar	ture	4000								

			1 - State State Registrar		epartment of He Ce <i>rtificate of D</i> e		Reg. No.	06 10724
	Dharini		1. Decedent's Name (First, Middle, Last)		T.	2. Date of Month	Death Day	3. Time of Death
	Physici /Medic		Walter McGuire			Apri		2006 1:15 p. M
7	Examin		4a. Facility Name (If not institution, give street and n	,	4b. City, Town, or Lo		4c. C	ounty of Death
			Franklin Square Hospi			sedale		Baltimore Co.
	Funeral		5. Social Security Number 6. Sex 1X M 2□ F	7. Age (In yrs. last birth			Day, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	73	13.	May 1	3, 192	6 Maryland
	/land		10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Man, L-f sh	to	Maryland Baltimore Co.	Fu	llerton			1 ☐ Yes 2 ☐ No
	r 28¢	Director	10e. Street and Number		10f. Zip Code		10g. Citize	n of What Country?
	th wit	aiD	7 Briar Hollow Court		21	.236	Un	ited States
	ems ems	Funerai	11. Marital Status 12. Was De	cedent Ever in U.S.	13. Was Decedent of Hisp	panic Origin? (Specify Yes or Mexican, Puerto Rican, etc.)		. Race - American Indian,
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be mailified at	by		2 Y No iive		Specify:		Black, White, etc. ^{pecify:} White
5-0	72 honatu	Completed	15. Decedent's Education (Specify only highest grade completed	16a. [Decedent's Usual Occupation 'Give kind of work done dur	on ring most of working	16b. Kind	of Business/Industry
21	within ene. than "	nple		(1-4or 5+)	life. DO NOT use retired)		C+a	al Industry
21	filed with Hygiene. other than	Co	8 yrs.		Crane Opera			el Industry
ng	be fill	Be	17. Father's Name (First, Middle, Last)		11	8. Mother's Name (First, Mid	ldle, Maiden Si	umame)
3	should be and Mental I marked o	Jo	Vincent McGuire				aily	
Maryland	12 sho h and 7 is mu trauma		19a. Informant's Name/Relationship (Type, Print)	_		d Number or Rural Route Nu		
e,	1 and Healt em 2 ther		Ms. Angela O'Dell / Daug 20a. Method of Disposition	11 001	Briar Hollo Disposition (Name of	w court Bal		Maryland 21236
ō	nt of		1 🖾 Burial 2 □ Cremation 3 □ Removal from	State cemetery	, crematory or other place)	l I		
Baltimore,	permit, Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Mich	ael E.Canapp	od Cemetery 22. Name and Address	April 5,200	U6 Bal	timore, MD
Ba	Dermi Depa Impo any Ir			aer c.canapp		•		Harford Rd
	3		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death. Do no	Leonard J	Ruck, Inc.		ore, MD 21214 Approximate
	Dhusisian		shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	1. 0	f. t:	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	yr as a consequence of	la In	gargier		suaden
	Examiner			Wi as a consequence of).			
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	(or as a consequence of	i):			
	cuted nd ransit	Examin	that initiated events					
oʻ	e exe	EX	resulting in death) Last Due to	(or as a consequence of	i):			
68760,	fficate be executed g physician and as the burial-transit	edicai	d					- Incomes
9 ×	75 0	Med	IF FEMALE:					
Вох	death certifi attending for use as	an/	23h Was decedent pregnant 23c. If yes, of	utcome of pregnancy birth 2 Petal death	3 □Ectopic pregnancy		230	d. Date of delivery Month Day Year
0.	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unk	nant at time of death	5 Other (specify)		_	Month Day Year
9.	The law requires that the death certi tte has been signed by the attending page 2 should be detached for use a	Ph	Part II. Other significant conditions contributing to	death but not regulting in	the underhing source grown	in Boot I 220 D	id tobacco uso	contribute to the cause of death?
of Vital Records,	signe d be	Completed by	. artim contact organical and a contact and contact an	oodii but not resulting iii	ine underlying cause given			No Probably 4 Unknown
Ö	w require been si should b	etec					:	
360	elaw hasl	ldm				24a. W	has an tropsy enformed?	24b. Were autopsy findings available prior to completion of cause of death?
a						1 ☐ Ye		1 ☐ Yes 2 No
×.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?		Other	6. Place of Death (Check on		
of	Phys rthis ral di	- T	1 Yes 2 No Hospital: 27. Manner of Death 28a. Date	Inpatient 2 ER/Outp	Jalient 3 DOA	4 Nursing Home 5 R	esidence 6 [be how injury o	
Division	ding h. After fune	tion	Natural 5 Pending (Mo.		ury Work?	s 2 No	be now injury c	occurred.
S	Atten deat ctor: y the	ca	3 Suicide 6 Could not be 28e Place	e of Injury - At home, farr			n (Street and I	Number or Rural Route Number,
_				ting, etc. (Specity)	n, shoot, ractory, onlos		Town, State)	Territoria de la constanta de
	after Dire	ertif						
۵	hours after hours after neral Dire filled in b	ai Certification;	29a. Certifier Physician: To the	e best of my knowledge,	death occurred at the time.	date and place, and due to t	the cause(s) an	nd manner as stated.
Ö	ne Hospital or a new more after a Funeral Direction block of the filled in E	edical Certif	29a. Certifier Sertifying Physician: To the (Check only Medical Examiner: On the	e best of my knowledge, basis of examination and men stayed.	death occurred at the time, or investigation, in my opin	date and place, and due to to ion, death occurred at the tin	the cause(s) ar ne, date and pl	nd manner as stated. ace, and due to the cause(s)
Ö	To the Hospital or Attending Physician: which 24 hours after death of the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certif	29a. Certifier Sertifying Physician: To the (Check only Medical Examiner: On the	basis of examination and	death occurred at the time, for investigation, in my opin	ion, death occurred at the tin	ne, date and pl	nd manner as stated. ace, and due to the cause(s) signed (Month, Day, Year)
Ö	To the Hospital or a within 24 hours after To the Funeral Dire completely filled in b	Medical Certif	29a. Certifier (Check only one) General Medical Examiner: On the and ma	basis of examination and	or investigation, in my opin	ion, death occurred at the tin	ne, date and pl	ace, and due to the cause(s)
ia	To the Hospital or within 24 hours after To the Funeral Dire completely filled in b	Medical Certif	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and addless of person who completed cat	basis of examination and	29c. License n	ion, death occurred at the tin	ne, date and pl	ace, and due to the cause(s)
10	6	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and addless of person who completed care	pasis of examination and partitions and staged. Second Staged. Second Staged. Second Secon	29c. License n	ion, death occurred at the tin	ne, date and pl	ace, and due to the cause(s)
Id	To the Hospital or a within 24 hours after within 24 hours after side of the Euroral Director of the Completely filled in Europe	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and addless of person who completed care	basis of examination and	29c. License n	ion, death occurred at the tin	ne, date and pl	ace, and due to the cause(s)

ORIGINAL

			For State Registrar	State of Ma	-	epartmen Certificat			d Ment	al Hygier	21115	10725
			Decedent's Name (First, Middle, La	ast)					1.4	ate of Death		3. Time of Death
	Physici /Medic		Romaine Matthews	s-Tyler					M	arch	25 200	/ 11 3 / 1 F M
	Examin		4a. Facility Name (If not institution, gi			4b-Gity,	Town, or	Location of D	eath		4c. County of Dea	ath
			St. Agnes M	ospital		Bo		9701				
	Funeral		o. coolar coracy / tamber	Sex V 7. Ago 1 □ M 2 💢 F	(In yrs. last birt	nday) If Under Months	Days Days	Hours N		ate of Birth fonth, Day, Ye		rthplace (State or Foreign country) UNK
	Director		218-58-4535 Usual Residence of Decedent	11	54	13.			Fe	b 20, 1	.952	
	land ow		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Man	ķ	MD Baltimo	re	Catons	ville						1 ☐ Yes 2√ No
	or 28:	lre	10e. Street and Number			10f. Zip	Code			10g.	Citizen of What C	Country?
	23a 23a	la l	16 Fursting Aven	ue		2	1228				USA	
920	be filed within 72 hours after death with the Maryland ital Hygiene. bd other than "natural", or iteme 23a or 28a-f ahow event, the Medical Exammer must be mailfied at	by Funeral Director	11. Marital Status 1 □ Never Married 2 🛱 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	unk	13. Was Dece If Yes, spe 1 \(\subseteq Yes	cify Cuba	spanic Origin n, Mexican, P Specify:	? (Specify Yuerto Rican	es or No- , etc.)	14. Race - Am Black, Wh Specify: b	
Maryland 21215-0036	vithin 72 ho ne. han "natur a Wedical I	Completed	15. Decedent's Elementary/Secondary (0-12)	ade completed) College (1-4or 5	(Give kind of work done during most of w life. DO NOT use retired)					unk 16b. Kind of Business/Industry		
d 2	filed Hygi ther		unk 17. Father's Name (First, Middle, Las	unk 1)			unk	. 18. Mother's	Name (Firs	t, Middle, Maid	den Sumame)	unk
au		To Be										
ary	S D E E	-	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address	(Street	and Number o	or Rural Rou	te Number, Ci	ty or Town, State,	Zip Code)
	1 and 2 Health a tem 27 is		St. Agnes Hospit	al		0 S. Ca		Avenue				
Baltimore,	Page nent o ent: ff ury or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☒ Other (Spec		cemeter	Disposition (Na v, crematory or o	me of other plac	θ)	Date	200	Location - City o	r Town, State
Balt	Departr Importe any Inje		21. Signature of Juneral Service, con Ronal d	11/1/18	egtor	Baltim	ore,	MD 2	1201		altimore	Street
			23a. Part1 Enter the disease, or con shock, or heert failure. List on	nplications that caused y one cause on each li	I the death. Do n	ot enter the mo	de of dyin	g, such as car	rdiac or resp	oiratory arrest,		Approximate interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Myo	caralia	Pato	CHi	٥٨				1 day
	/Medical Examiner		resulting in death)	Due to (6) as	a consequence	Vain	ل عمد	mci C				1 12
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a eoneequence o	17270	عادا ها	رادن	-			Cag
	cuted	Examine	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.								
oʻ	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):						
8760,	ate b	llca		d								-
9	ertific ding p	/Wec	IF FEMALE:	23c. If yes, outcome	of programmy						and Date of d	Alternation of the second
P.O. Box	The law requires that the death certificate be executed atte has been signed by the attending physician and baga 2 should be detached for use as the burial-transli	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ØNo 9 ☐ Unknown		2 Fetal death	3 ☐Ectopic p 5 ☐ Other (s					23d. Date of d Month	Day Year
	res that igned b	by PI	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlying	cause giv	en in Part I.	1			to the cause of death?
ord	w require been sig								_	1 🗌 Yes	2∐No 3∏I	Probably 4 Unknown
Vital Records,	fhe law r le has be aga 2 sh	Completed							-	24a. Was an autopsy performed □ Yes 2	prior to death?	autopsy findings available o completion of cause of
ita		0	25. Was case referred to medical					26. Place of		eck only one	32	
of V	Physician: this certific ral director.	To B	examiner? 1 ☐ Yes 2 DYNo	Hospital: 1 Xinpatio	ent 2 ER/Ou			4 LI Nursi	ing Home	5 🗌 Residence	e 6 ⊡Other (Sp	necify)
ion o	ling After Tune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inju (Month, Da on		ime of njury M	28c. Injur Wor 1 🗀	yat k? Yes 2 □ No		Describe how i	injury occurred	
Division	al or Atte s after de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of in	ury - At home, la c. (Specify)	rm, street, facto	y, office			ocation (Stree City or Town, S		Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical (Physician: To the best aminer: On the basis of and manner st	f examination an							
	To the withing To the comp	×	29b. Signature and title of certifier	esident	Doctor	F .	c. Licens	5 09		29d. M	Date signed (Mon	onth, Day, Year) 25, 2006
			30. Name and address of person who	eqimenci	900	Caton	A	venue	Ba	ltimore	2 MD	21229
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 6 260	32. Registi	rar's Signature	ريه						
					-							

Matthews-Tyler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month Robert Cullins O'Brien 2006 1:25 PM April April 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Keswick MultiCare Center Baltimore 8. Date of Birth (Month, Day, Year)
Aug. 27, 1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 1 ☑ M 2 ☐ F 315-20-3694 1923 Kentucky Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1434 Redfern Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2X Married Specify: White 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pile Driver Union Shop 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kelly O'Brien Daisy Lee Call 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn O'Brien 1434 Redfern Avenue, Baltimore, Maryland 21211 Wife 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dulaney Valley 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 04/06/2006 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burvey—Henss—Seitz Funeral Home, Inc. 3631 Falls Koad, Baltimore, Maryland 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA years END STAGE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown DISORDER 1 Yes 2 No 3 Probably SEIZEU 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? NEW-ONSET 2/Q/No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Jeath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

MdSe:1 attending physician I for use as the buria signed by the at Id be detached fo o Records, peen Vital To tha Hospital or Attanding Phys within 24 hours after death.

To the Funaral Director: After this completely filled in by the funeral dir o,

Physician

/Medical

Examiner

Funeral

Director

rthan "natural", or Itams 23a or 28a-f shov the Medical Ever-inermust be notified at

marked other than

othar

Department of Important: If any injury or once. ò

Physician

Examiner

/Medical

Pages 1 and 2 should be fil tment of Health and Mental H tant: It itam 27 is marked ott

Baltimore, Maryland 21215-0036

Direct

δ

Completed

Physician/Medical Completed by

9 ☐ Unknown

MYELOPROLIFERATIVE

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

> 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 🗀 Suicide

4 Homicide

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

6 2006

D25643

SUITE 209

harles

29d. Date signed (Month, Day, Year) 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Medical

Kendal R. Faulaner MD/6505 31. Date filed (Month, Day, Year) State

APR 0

32. Registrar's Signature



		1	For State Registrar	State o	of Marylar	•	artment of H			giene Reg. No.	006	10727
			Decedent's Name (First, Middle, Las	!)					2. Date of Dea	ath		3. Time of Death
Phy:		_	Herbert Ode	ssey					April 3	Day 200	Year)6	11:50 P M
	edica mine		4a. Facility Name (If not institution, give		ımber)		4b. City, Town, or	Location of Dea		T	ounty of Death	111.50_1
Exa	1111111	=1	6150 Parkway Driv		. Floor		Baltimo	ra			N/A	
Fune	ral		5. Social Security Number 6. Se		7. Age (In yrs.	. last birthday)	If Under 1 Year	If Under 24 Hrs	s. 8. Date of Birt	h Vans	9. Birth	place (State or Foreign
Direct			182-26-0929	∑ M 2□F	70	Yrs.	Months Days	Hours Min	May 3		Penns	svlvania
9		- H	Usual Residence of Decedent									
ırylar Phow	1	.	10a. State 10b. County		10c. C	ity, Town or Lo	ecation					10d. Inside City Limits 1√2 Yes 2 □ No
e Ma		Director	Maryland N/A			Baltin	nore					
if th		흥	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
ath w		<u></u>	6150 Parkway Driv		. Floor		2121				U.S.A.	
e de		Funeral	11. Marital Status	Armed Fo		J.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (: n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	- 14	 Race - America Black, White, 	
36 saffe		by F.	1 Never Married 2 Married	1 ☐ Yes If Yes, Gi	ive		1 ☐ Yes 2 ☐ No	Specify:		5	Specify: Whi	to
d 21215-0036 Itied within 72 hours after death with the Maryland Hygiene. Thysiene. Softer than "natural; or Iteme 23a or 28a-1 ehow ant, the Medical Examinar must be notilied at		g P	3 Widowed 4 □ Divorced 15. Decedent's Ed	Year or D	Dates:	_,	dent's Usual Occupa	tion		10h Kin	d of Business/In	
15 n 72 n and		Completed	(Specify only highest grad	ie completed)		(Give	kind of work done d DO NOT use retired,	turina most of we	orking	IOU. KIIK	u or businessym	dustry
with and a		Ĕ	Elementary/Secondary (0-12)	College (4	(1-4or 5+)			ngineer		Def	ense	
Hyginal 1			17. Father's Name (First, Middle, Last)			LILECT	.TICAT III		me (First, Middle,			
□ 8 = 5 ≥		To Be	Edward	00	lessey			Esther			Tell	er
should in marke			19a. Informant's Name/Relationship (7		acoscy	19b. Mailie	ng Address (Street a			r, City or		
Mar nd 2 sho ith and 27 is my			Robert Odessey/S	on		6150) Parkway	Dr. 2nd	. Floor	Balti	more N	D 21212
ore, Ma or 1 and 2 or Health an item 27 is		ŀ	20a. Method of Disposition		20b.	Place of Dispo	sition (Name of		Date		ation - City or To	
Baltimore, bermit. Pages 1 ar Department of Hea Important: If Item			1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		State	-	matory or other place		2006	Do 1	timoro	MD
Balting permit. Pa Department Important		-	21. Signature of Euneral Service Licen:		Ме	tro Cre	2. Name and Addres		2006	рал	ltimore	FID
Baltimore permit. Pages: Department of temportant: If its	o o		1 2 /	<u> </u>		-	Miller	-Dippel	Funeral load Bal	Home	Inc.	21206
			23a. Part 1. Enter the disease or comp	lications that	sed the dea	ith. Do not ent					e m	Approximate
		1	shock, or heart failure of only o	ine cause on i	each line.	/						Interval Between Onset and Death
Pnysici /Medic	_		disease or condition resulting in death)	a	w	Lon	CANCE	10				year
Examin				Due to	(or as a conse	quence of):						0
110		- a	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	quence of):						
W 5 5		Examiner	Cause (Disease or injury									
axecu and		xai	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):						
18760, cate be executed physician and the burial-transit	3	dlcal		d								
687 ilicate		듛		9.								
Box 6 leath certifications attending	9	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr					23	3d. Date of deliv	ery
Box leath cert attendin	5	<u>C</u>	in the past 12 months?		birth 2 Tet nant at time of		Dectopic pregnancy Other (specify)			- 1	Month	Day Year
that the der		S	9 Unknown	9□ Unkn	nown							
Records, P.O. Box 6 The law requires that the death certifit tens been signed by the attending to			Part II. Other significant conditions co	ontributing to c	death but not re	sulting in the u	nderlying cause give	on in Part I.	23e. Did t	obacco us	e contribute to t	he cause of death?
ds sign		d by							10	res 2	No 3□ Prol	bably 4 Unknown
Vital Records, sician: The law requires to certificate has been signed reactor name 2 should be considered.		Completed							24a. Was	an	24b. Were auto	opsy findings available
The lay	9	E							autop	rmed?	prior to co death?	impletion of cause of
		ပိ	25. Was case referred to medical					OC Place of D	1 Yes	2 XNo	1 🗆 Yes	2 No
		o Be	examiner?	Hospital:	Inpatient 2] ER/Outpatier	nt 3 DOA Othe		eath <i>(Check only o</i> Home 5 ☐ Resid		MOther (Spec	50n5
Division of lor Attending Physical death. Director: After this	8	\vdash	27. Manner of Death	28a. Date	of Injury	28b. Time o			28d. Describe I			y) residence
VISION Attending r death.		후	1 Natural 5 Pending investigation		nth, Day Year)	Injury		k? Yes 2∐No				
Attendia death.		‡ ‡	3 Suicide 6 Could not be	28e. Plac	e of Injury - At I	home, farm, st	reet, factory, office				Number or Run	al Route Number,
Distance of the property of th		Certification;	4 Homicide	build	ding, etc. (Spec	rify)			City or To	wn, State)		
DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funarel Director: Allorians in the funarel in the funarel			29a. Certifier 1 Certifying Ph	ysician: To th	e best of my kn	nowledge, deat	h occurred at the tim	ne, date and place	ce, and due to the	cause(s) a	and manner as s	stated.
Ho Ho	9	edical	(Check only 2 Medical Examone)		basis of examin nner stated.	nation and/or in	vestigation, in my or	oinion, death occ	curred at the time,	date and p	place, and due t	o the cause(s)
To the within 2 To the		-	29b. Signature and title of certifier	4 0			29c. License	number		29d. Date	signed (Month,	Day, Year)
			M. Ar Thone	Kily.	usp		02	5205		Apri	16 4,2	2006
			30. Name and address of person who	cau	use of death (ite	em 23a) (Type,	Print)	0. 0	01	1 11 40	15:	206
<u></u>	9		30. Name and address of person who of the filed (Month, Day, Year)	O Br	nc 6	701 1	V. Char	US 57	- walt	o. m	(1 4	20/
BOIL OF	Sta	te	31. Date filed (Month, Day, Year)	32.1	Registrar's Sign	nature	ð					
Rec	gistr	ar	APR 0 6 2006	Par allen	L B	A STATE OF THE PARTY OF THE PAR	-8					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** PLAYER MARTHA 1:58 4-5-2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Catonsville Commons Nursing Home Catonsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🛣 F 224-20-4886 84 Director KY Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or iteme 23a or 28a-f ehow idical Examiner must be notified at 1X Yes 2 No Director Baltimore City Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2419 Herkimer Street 21230 U.S.A. filed within 72 hours efter death thygiene. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married jo, Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked off Fred Kiser Lucinda Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Daniel E. Player / son 2419 Herkimer Street; Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ŏ 1 ☐ Burial 2X Cremation 3 ☐ Removal from State ortant: 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation | 4-6-2006 Stevensville, MD permit.
Departn
Imports
any nju 22. Name and Address of FacilitySingleton Funeral Home, PA 21. Signati 1 Second Ave SW; Glen Burnie, MD 21061 mon de Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm Mate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' 2 □ No 2 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 1 ☐ Yes 2 No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 | Homicide within 24 hours e 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) UKAKYIA 1009 frederick 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		-	For State Registrar	Stat	e of M	aryland / I		artment rtificate				lental Hy	giene Reg. No.	000	10729
	Physicia /Medic		1. Decedent's Name (First, Middle RG PL		PIH	men						2. Date of D Month	eath Apr 4,	2006 Year	3. Time of Death 11:45 p M
	Examin		4a. Facility Name (If not institution	on, give street ar Future Car				4b. City, 7	ľown, o	Location	of Death Baltin	nore	4c.	County of Death Balti	
je.	Funeral Director		5. Social Security Number 218-18-5743	6. Sex 1 🔀 M 2	7. Ag	ge (In yrs. last bi	rthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Sep 2	rth ay, Year) 3, 192	9. Birth Col	place (State or Foreign intry) Carolina
	Maryland f show		Usual Residence of Decedent 10a. State 10b. County Maryland	N/A		10c. City, Tow	n or Lo	ocation	Ba	altimore)	•			10d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28e	al Director	10e. Street and Number 3719 West Coldspri	ng Lane		.1		10f. Zip	Code	212	15		10g. Cit	izen of What Co. U.S.	
920	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other traumatic event. Ita Madical Exarifret must be rutilized at ODEs.	by Fur	11. Marital Status 1 Never Married 2 Mai 3 Widowed 4 Divorces	rried 1 If Ye	Decedent ed Forces? Yes 2 X es, Give r or Dates:			Was Deced If Yes, spec 1 Yes 2		ispanic Or in, Mexica Specify		ecify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White Specify:	
21215-0036	within 72 he ene. then "netu	Completed	(Specify only higher Elementary/Secondary (0-12)		eted) ege (1-4or		(Give	dent's Usua kind of won DO NOT us	k done e retired	durina mo:		ing	16b. Ki	ind of Business/l Bethlehe	
Maryland 2	12 should be filed within in and Mental Hygiene. 7 is marked other than " issumatic avant. It a Mac	To Be Co	12 17. Father's Name <i>(First, Middle</i> Der	npey Pittm	an					18. Moth	er's Name	a (First, Middl	e, Maiden Olive I		
	and 2 shousalth and N n 27 is mailer traumail		19a. Informant's Name/Relation Margo Pittman Date		t)	191		-				al Route Numi imore, Ma		or Town, State, Z. 21215	ip Code)
Baltimore,	Peges 1 annount of He ant: If Itam ury or oth		20a. Method of Disposition 1 🗷 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (from State		ry, crer	natory or of Ridge	her plac	1		04/11/06	20c. Lo	Pikesville, I	
Balt	permit. Depertrimportu		21. Signature of Funeral Service	Licensee)al	Report) 22		tep B	rothers	Funer	al Service Itimore, M		17	
	Physician /Medical		23a. 11. Enter the disease, c shock, or he in failure. Lis Immediate Cause (Final disease or condition resulting in death)	a		- 3/	198					or respiratory			Approximate Interval Between Onset and Death
V	cate be executed by sicien end in the burial-transit	Ш	Securitially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c		a consequence	of): \C\(en:	ınu	S -	mo	In	Q		
68760,	licate be physicie s the bur	edicai		d.			Th	no lo	11 €	Sn	con				
P.O. Box (The law requires thet the deeth certificate hes been signed by the attending page 2 should be detached for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	10	Live birth	e of pregnancy 2 Fetal death It time of death		Ectopic pre Other (spe		,				23d. Date of deli Month	very Day Year
	w requires that been signed b should be deta	۵	Part II. Other significant condit	,	g to death t	but not resulting	in the u	inderlying ca	tuse giv	en in Part	1.		tobacco i		the cause of death?
I Records,	@ <u>~</u>	Completed		orter othyr	<u> १८ १</u>		Di	9 be	he	mel	 Dytu	000	s an opsy formed? 2 No	prior to death?	opsy findings available ompletion of cause of 2 No
of Vital	Physician: The this certificate ral director, pag	To Be (25. Was case referred to medice examiner? 1 Yes 2 No	al Hospital:	1 🗌 Inpati	ent 2 ER/O			Oth	26. Plac	e of Deat	h (Check only		6 ☐Other (Spec	ify)
	E E	ertification:	= - 1.1001GOIN	ing tigation	Date of Inju (Month, Da	ury 28b.	Time o	f 21	Bc. Injur Wor 1 🗆			28d. Describe			
Division	i or Attendii eiter death. Diractor: A in by the fu	ertific	3 Suicide 6 Could 4 Homicide deten	not be 28e.		jury - At home, f tc. (Specify)	arm, str	reet, factory	, office				(Street ar		ral Route Number,

Medical

State Registrar

within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag To the Hospitel or Attending Physician: The

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

APR 0 6 2006

29a. Certifier

30115

415/6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ohiorpeher, mo 2600 LIBOR 31. Date filed (Month, Day, Year)-

32. Signature

Herrs Thre

Ball , mo 21215

DHMH 17 Rev 1/2001

			State of Maryland / Dep State Amend Item 23a per Dr., G854,04	artment of Health and M Mile Care Death	1ental Hygi ₽•	ene g. no. 0 6	10730
	Physici		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) RVAN		2. Date of Death		3. Time of Death 2:05 Am
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 340 Chiseled Stone	4b. City, Town, or Location of Death Sykesville		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 $\square X$ M 2 \square F 85 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day) Oct 8 I	year) 9. Birth Cou	place (State or Foreign intry)
	e Marylan 8a-f ehow alified at	ctor	10a. State 10b. County 10c. City, Town or L Sykesvil	le			10d. Inside City Limits 1 ☐ Yes 2 ☐ Mio
	eth with the 23e or 2	Funeral Director	10e. Street and Number 340 Chiseled Stone	10f. Zip Code 21784		USA	
900	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Iteme 23e or 28e-f ehow any injury or other treumatic event, "In Medical Examinar must be motified at once.	5	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No WW ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerio 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	, etc.
21215-0036	d within 72 h giene. or then "natu	Completed	(Specify only highest grade completed) (Given if the secondary (0-12) College (1-4or 5+)	ident's Usual Occupation I kind of work done during most of work DO NOT use retired) ER CARRIER	ing	6b. Kind of Business/I J.S. Postal	•
Maryland	ould be filed I Mental Hygid Parked other Patic svent, L	To Be C	17. Father's Name (First, Middle, Last) Michael John Ryan	18. Mother's Name Marie Ba	111		
	l and 2 sho leelth and m 27 is m her treum		Michael Joseph Ryan (son) 340	ing Address (Street and Number or Rum Chiseled Stone, Sy	kesville	e, Md 21784	
Baltimore,	t. Pages I rtment of H rtent: If Ite		4 Donation 5 Other (Specify)	ty Cremation 4-2-	-06 S	Sykesville,	Md
Ba	permit. Deportr Imports any nij			2. Name and Address of Facility Hai	ville, Md	21784	Chapel
8760,	Cale be executed / Medical Examiner / Medical Examiner : the pnijal-Itausit : the pnijal-Itau	ai Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	to thrive			Interval Between Onset and Death
P.O. Box 687	The law requires that the death certificate sie has been signed by the attending phyrpage 2 should be detached for use as the	Completed by Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	rery Day Year
	w requires that been signed b should be deta	ed by Pt	Part II. Other significant conditions contributing to death but not resulting in the o	underlying cause given in Part I.	23e. Did toba	acco use contribute to	
al Records,		Comple			24a. Was an autopsy perform 1 🗆 Yes 2	prior to co	opsy findings available ompletion of cause of
of Vita	Physician: The I this certificate har al director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 2 2 2 2 2 2 2 2	nt 3 DOA Other: 4 Nursing Ho	me 5 Resider 28d. Describe how	nce 6 Other (Speci	fy)
Division of Vital	To the Hospital or Attending Phywithin 24 hours after deeth. To the Funeral Director: After thi complately filled in by the funeral	Certification:	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined determined	Work? M 1 Tes 2 No	28f. Location (Stre	eet and Number or Rui	al Route Number,
Ö	spital or hours afte ineral Dire		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place,	City or Town, and due to the car	use(s) and manner as	stated.
	To the Ho within 24 I To the Fu complatel	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated. 29b. Signature and the of certifier	29c. license number		te and place, and due	
			30. Alame and address of person who completed cause of death (Item 23a) (Type	Print) 0 1 = 1	8 11	larch 31	,2006
	Sta	te	HVa S. Da Ker M.D. 710 Obrect 31. Date filed (Month, Day, Year) 32. Registrar's Signature	IT Koad Sykos	IVILLE M	10 2175	4
	Registr	ar	APR 0 6 2006				

			For State Registrar	State o	f Marylan		artment of H		and Mental	Hygien Reg. N	1000	10731
12 ggs	Physici		1. Decedent's Name (First, Middle, Gladys	Lasi) Theresa		Robe	rts		2. Date	of Death	Pay 2006	3. Time of Death 3. 55 A ^M
	/Medic Examir		4a. Facility Name (If not institution, Doctors Hos		nber)		4b. City, Town, or Lanham				c. County of Death Prince Ge	
P.	Funeral Director	1	220-32-6681	5. Sex 1 ☐ M 2 ☐ X F	7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date Min. (Mon. Apri	of Birth h, Day, Yea 29, I	9. Birth 934 Mary	place (State or Foreign ntry) Land
	n the Maryland	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (10e. Street and Number	George's		y, Town or Lo Capitol	Heights			10g. (Citizen of What Cou	1 Od. Inside City Limits 1 ☐ Yes 2 🛣 No
336	o 72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f ehow official Examinationals by notified at	Funeral	11.14 Capitol He 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dece Armed Fo	edent Ever in U. rces? 2 X No		20743 Was Decedent of H f Yes, specify Cuba 1 □ Yes 2 No		gin? (Specify Yes , Puerto Rican, et	or No-	U.S.A. 14. Race - Ameri Black, White, Specify: Afri	etc.
Maryland 21215-0036	y within plene. r than "	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th	Education grade completed) Cotlege (1	-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired emaker	ation during most I)	of working	16b.	Kind of Business/In	
land	should be filed nd Mental Hygis marked other matic event, II	To Be C	17. Father's Name (First, Middle, L Robert H	arley					r's Name <i>(First, N</i> ose Ella			
	12 sh h and 7 Is m traum	13	19a. Informant's Name/Relationshi Kevin Roberts								or Town, State, Zij .ol Height	Code) S, MD20743
Baltimore,			20a. Method of Disposition 1 M Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Chair C	emetery, crer	sition (Name of matory or other place tion Ceme	e) tery	April 7, 2006		Location - City or To .nton, Mar	
Balt	permit. Pag Department Important: II eny Injury o once.		21. Signature of Funeral ServingL	0 1	10146	4 66	33 Old A	lexand	dria Feri	y Roa	Home, Ind	n, MD20735
0	Physician hysician and hysician and physician and physician and the printing the printing that the pri	lical Examiner	23a. Part1. Enter the disease, or cachock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acut Due to b. Seve Carc C. Due to	ach line. .e Recut (or as a conseq	uence of): Dinary A uence of): C Shock uence of):	Myocardia Artery Di	l Infa				Approximate Interval Between Onset and Death 4 Days
.O. Box 6	The law requires that the death certificate be executed the has been signed by the ettending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	come of pregna irth 2 Feta ant at time of d	Ideath 3	Ectopic pregnancy Other (specify)			_	23d. Date of deliv Month	ery Day Year
0	quires that n signed b	þ	Part II. Other significant condition Pulmonary		eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e.	Did tobacc	o use contribute to I	he cause of death?
of Vital Records,		Completed	Ischemic	Cardiomyo	pathy				24a.	Was an autopsy performed?	prior to co	opsy findings available impletion of cause of
Vita	eicien: 1 certifical irector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: , x		150/0	oth Oth	0.00	of Death (Check		a C700 (2)	
Division of Vit	To the Hospital or Attanding Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely illied in by the funeral director.	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	28a. Date (Moni	th, Day Year)	28b. Time o Injury	f 28c. Injun Wor M 1	4 🗆 140	28d. Des	cribe how in	6 ☐Other (Speci	
Divi	spital or Attendours after deatl		4 Homicide determin	ed 286. Place	of Injury - At he ng, etc. (Specif		eet, factory, office			or Town, St	and Number or Rur ate)	al Houte Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical E	xaminer; On the b	best of my kno asis of examina ner stated.	owledge, death ation and/or in	vestigation, in my o	pinion, deal	d place, and due t th occurred at the	time, date a	(s) and manner as sand place, and due t	o the cause(s)
)	ų	Σ	29b. Signature and title of certifier	1+31	10		29c. Licens	0 75	7	41	Date signed (Month,	Dāy, Year)
	10	15		00 Good I	Luck Roa	ad Suit	te 302 La	nham,	Marylan	1 2070	06	
	Sta Regist	3	31. Date filed (APPRO 7. Year) 2	006	legistrar's Signa	ture						

			For State Registrar	State of Ma	arylan	d / Depa		of He	ealth a				nn	6	1073	2
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, La Clinton Joh A. Facility Name (If not institution, giv	n Rock	1e	Jr.	4b. City, To	wn, or L	ocation of	f Death	2. Date of De Month	Da	1	Zear 2006 of Death	3. Time of De 0054	ath M
É	Funeral Director		University of Mary 5. Social Security Number 218 44 5389	ex 7. Age		last birthday)	If Under 1		If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h y, Year)		9. Birthpl Count		-
	D	ž	Usual Residence of Decedent 10a. State 10b. County	x 59		y, Town or Lo					April 4	1946)		ore, Mary	imits
	h with the M 3a or 28a-f at be notifie	al Director	Maryland Baltimore 10e. Street and Number 7 Luffing Court		Balt	timore C	10f. Zip Co 21221			-		10g. Cit		What Count	1 □ Yes 2 [ry?	X No
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or Itema 23a or 28a-1 ehow event, the Madical Exeminal must be collised at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 M If Yes, Give Year or Dates:		'		t of Hisp Cuban,	panic Orig , Mexican, Specify:	gin? (Spe Puerto F	cify Yes or No Rican, etc.)		14. Rac	e - America ck, White, e	tc.	
2121	nn 72	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12		+)	(Give	tent's Usual C kind of work o DO NOT use i Technic	done du retired)	ion iring most	of workin	ng	16b. K		usiness/Ind	ustry	
Maryland	2 should be filed within and Mental Hygiene. ie marked other then aumatic event, the Mi	To Be (17. Father's Name (First, Middle, Last) Clinton J Roche 19a. Informant's Name/Relationship (19b. Mailir	ng Address /S	D	oris 1	P Kita	(First, Middle, zmiller Route Numbe			,	Codol	
altimore, Ma	permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 ie marked any injury or other traumatic e once.		Joyce Roche 20a. Method of Disposition 1 \$\mathbb{X}\$ Burial 2 \(\subseteq \text{Cremation 3} \) 4 \(\subseteq \text{Donation 5} \) Other (Specification 1)	Removal from State	c	_	ffing Co sition (Name natory or othe	of or place)	Balt	timore	e,Marylar ata	nd 21	221 ocation -	City or Tov	vn, State	
Balti	permit. Page Department of Important: If any njury or once.		21. Signature of Funeral Service Licer 23a. Part1. Enter the disease, or comshock, or heart failure. List only	1500		22	. Name and A	Address	of Facility	ne Try					Approximate	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. ISCHEMIN Due to (or as a	C CO	uence of):	nyopat	hy							Interval Betwee Onset and Dea 10 UCA	th
,09/8	ate be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a d.	a consequ	uence of):	i ma								citop	
O. BOX 6	the death certifi y the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 □ Live birth 24 □ Pregnant at 9 □ Unknown	2 Fetal] C ntaèbl	Ectopic pregri						23d. Dai Mo	le of deliver	y Day Year	
7	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions c	ontributing to death bu	it not resi	ulting in the ur	iderlying caus	e given	in Part I.			es 2		ribute to the	cause of death	
vital Records,	The ete h page	e Completed	25. Was case referred to medical									sy πed? 2 X No		Were autop prior to com death?	sy findings avai pletion of cause	lable of
Division of Vi	he Hospital or Attending Physical Carlos of Attending Physical Discourt Affect This pletely filled in by the funeral discourt of the funeral discourt of the funeral discourt of the funeral discourt of the funeral discour	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatier 28a. Date of Injun (Month, Day)	v	ER/Outpatien 28b. Time of Injury		Other: Injury a Work?	4 ☐ Nur	sing Hom	(Check only only only only only only only only	ence				
		al Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injubulding, etc	. (Specify	<i>'</i>)			-		City or Tow	n, State)		Route Number,	
		Medical	(Check only one) 2 Medical Examone) 29b. Signature and title of certifier	niner: On the basis of and manner stat		tion and/or inv	estigation, in	cense r	number	occurre	d at the time, o	late and	e signe	and due to	he cause(s) ay, Year)	
ĺ	00		30. Name and address of person who of Chi-Na Pak, M.D.	completed cause of de 22 S. Green	ath (Item	M.D. 23a) (Type, I	Print)		1201	4		A	pril	2,2	006	
	Sta Registr			32. Jegistra				11/2	-141							

		Registrar			Ce	rtificate of	Death		Reg. No. UU 6	10/00
ıysici Medic		Decedent's Name (First, Mid		William	Roberts	son		2. Date of De Month	Day Yea	
kamin		4a. Facility Name (If not institution of the ST AGNES) 5. Social Security Number	,	TAL	In yrs. last birthday	4b. City, Town, o		altimore		eath altimore Lirthplace (State or Fore
neral ector		250-12-2952 Usual Residence of Decedent	1 🔀 M 2		86 Yrs.	Months Days		Ain. (Month, Da	y, Year)	So. Carolina
iffed at	ctor	10a. State 10b. Coun Maryland	N/A	10	0c. City, Town or L		altimore			10d. Inside City Lin 1 MYes 2 □
at be no	al Director	10e. Street and Number 911 West Barre St	reet			10f. Zip Code	21230		10g. Citizen of What U.	Country? S.A.
the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 N Widowed 4 Divorce	arried 1 If Y	s Decedent Evened Forces? Yes 2 No es, Give ar or Dates:	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ② No	lispanic Origin? an, Mexican, Pi Specify:	? (Specify Yes or No uerto Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, hite, etc. Black
Ins Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)		leted) lege (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired Op	during most of	working	16b. Kind of Busines Maryland C	ss/Industry up Corporation
other traumatic event, II	To Be (17. Father's Name (First, Middle He	e, Last) nry Roberts	son			18. Mother's	Name (First, Middle Beatr	Maiden Sumame) ice Robertson	
er trauma		19a. Informant's Name/Relation	nship (Type, Prir	nt)		-		r Rural Route Numb More, Marylan	er, City or Town, State d 21230	, Zip Code)
parmit. Fagas 1 and 2 beparmant of Haalth important: if item 27 any injury or other tra once.		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other		1		osition (Name of matory or other place tus Memorial		Date 04/04/06	20c. Location - City -	or Town, State e, Maryland
		21. Signature of Funeral Service	ce Licensee	Ster] 2	2. Name and Addre Estep B	rothers Fu	ineral Service, Baltimore, Mo	P. A. 1 21217	
cian lical		Immediate Cause (Final disease or condition resulting in death)	a	ITTER	(9/15	TROINTE	37 INH	- BU12	EDING-	UKNOWN
ine purial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	ue to (or as a co	onsequence of):	ח's				
for use as the burial-transit	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	due to (or as a co	onsequence of): onsequence of): onsequence of): pregnancy Fetal death 3				23d. Date of c	
ba datachad for use as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions.	c d	tue to (or as a contract to the contract to th	onsequence of): onsequence of): onsequence of): pregnancy Fetal death 3 te of death 5 ont resulting in the contract	☐Ectopic pregnancy	en in Part I.	23e. Did t	23d. Date of o Month obacco use contribute	lelivery Day Year
page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condi	c	tue to (or as a contract to the contract to th	onsequence of): onsequence of): onsequence of): pregnancy Fetal death 3 te of death 5 ont resulting in the contract	□Ectopic pregnancy □ Other (specify) □	en in Part I.	23e. Did t 1	23d. Date of of Month obacco use contribute Yes 2 No 3 and 24b. Were prior to death 22 No 1 Yes	lelivery Day Year to the cause of death Probably 4 Duhkn autopsy findings avail
tha funaral diractor, page 2 should ba datachad for use as tha burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	ue to (or as a consultation of the consultatio	onsequence of): onsequence of): onsequence of): onsequence of): pregnancy Fetal death 5 [not resulting in the order of the order	□Ectopic pregnancy □ Other (specify) □ underlying cause giv C / OENT ont 3□ DOA Oth of 28c. Injur Wor M 1□	en in Part I. 26. Place of lef: 4 □ Nursin	23e. Did t 1 24a. Was auto perfo 1 Yes Death Check on to ag Home 5 Resi 28d. Describe	23d. Date of of Month obacco use contribute Yes 2 No 3 an 24b. Were prior to death to death to death to me! dence 6 Other (S) now injury occurred	lelivery Day Year to the cause of death Probably 4 donkin- autopsy findings avail o completion of cause es 2 No
in by tha tunaral diractor, page 2 should be datachad for use as tha burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	pue to (or as a consultation of the consultati	onsequence of): onsequence of): onsequence of): onsequence of): pregnancy Fetal death 5 not resulting in the of death 5 ZER/Outpatie ear) 28b. Time of Injury - At home, farm, st Specify)	D'S DEctopic pregnancy Other (specify) underlying cause giv C / DENT at 3 DOA 28c. Injur Wor M 1 Dreet, factory, office	en in Part I. 26. Place of lef: 4 □ Nursin yat k? Yes 2 □ No	23e. Did t 1 24a. Was autor performed to the control of the contr	23d. Date of of Month obacco use contribute Yes 2 No 3 an 24b. Were prior to death 1 Young dence 6 Other (S) now injury occurred	to the cause of death Probably 4 down autopsy findings avail o completion of cause es 2 No pecify) Rural Route Number,
funaral diractor, page 2 should ba datachad for use as tha burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	pue to (or as a contract to (o	onsequence of): onsequence of): onsequence of): onsequence of): onsequence of): onsequence of): organacy Fetal death 3[not resulting in the organization and/or in the organiz	DEctopic pregnancy Other (specify) underlying cause giv C / DENT at 3 DOA 28c. Injur Wor M 1 D reet, factory, office the constructed at the temperature of the construction of the co	en in Part I. 26. Place of er: 4 \(\text{Nursing yat k?} \) Yes 2 \(\text{No} \) No date and pupinion, death of enumber	23e. Did t 1 24a. Was auto perfc 1 Yes Death Check only of 28d. Describe 28f. Location (City or Tot courred at the time,	23d. Date of of Month obacco use contribute Yes 2 No 3 an 24b. Were prior to death 1 Yes 2 No 1 Yes dence 6 Other (S) how injury occurred	lelivery Day Year to the cause of death Probably 4 Donkin autopsy findings avail o completion of cause es 2 No Decify) Rural Route Number, ue to the cause(s) nth, Day, Year)

ORIGINAL

WILLIAM ROBERTSON

			For State Registrar	State of Ma	•	partmer ertificat			nd Me		iene	6	10734
ell (Physici /Medic	an	1. Decedent's Name (First, Middle Last)	GERS						Date of Dear	Day _	Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s	treet and number)		B	AUT	[]	rE		4c. County	of Death	
45.5	Funeral Director		214-36-3934	M 2□F	(In yrs. last birthd	Months	r 1 Year Days	If Under 24 Hours	Min.	B. Date of Birth (Month, Day, FEB 14	Year)	Cou	place (State or Foreign intry) ARYLAND
Maryland	In show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND N/A		10c. City, Town o	LTIMOR	E						10d. Inside City Limits 1 □XYes 2 □ No
with the	3a or 28s	I Director	10e. Street and Number 1102 DRUID HILL A	VENUE AP	г 711		Code 212	01		1	0g. Citizen of U.S.A		intry?
-0036 hours after death with the Maryland	"natural", or items 23a or 28a-f show rdical Examinar must be notified at	by Funeral		2. Was Decedent E Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:		3. Was Dece If Yes, spe	erity Cubai	spanic Origi n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)	Bla	ce - Amer ck, White	
1215- within 72	ene. than "na he Madic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2 th (GED)	ation completed) College (1-4or 5+	-) (G	ocedent's Usu ive kind of wo e. DO NOT L	ork done d ise retired,	uring most (7	16b. Kind of B		,
pu e	ntal Hygi ed other event, I	To Be Co	17. Father's Name (First, Middle, Last) ROBERT ROGERS					18. Mother			Maiden Sumar		
	ulth and 27 Is m r traum		19a. Informant's Name/Relationship (Type Dorothy Dixon/Clo			_					r, City or Town		p Code) ad 21217
altimore,	or of the		20a. Method of Disposition PCMSurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		20b. Place of Di	sposition (Na crematory or	me of other place	9)	Da	te	20c. Location	City or T	
Balti permit.	Baltimo permit. Pag Department Important: any njury o		21. Signatur — icense	8		22. Name a WILLI 1206 N	AM C	BROWN	COM	MUNITY	FUNERA	L HO	ME P.A.
Physician /Medical		26a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line	on movie	A	de of dying	g, such as c	ardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death	
E	kaminer	dical Examiner	Sequentially list conditions, if any, leading to infine-diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Co (or as a	consequence of):								yes
O. Box 68	by the attending phys tached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s				T-4500 (13.12.12.13.14.13.13.14.13.14.13.14.13.14.13.14.13.14.13.14.13.14.13.14.13.14.13.14.13.14.13.14.13.14.		ite of deli-	very Day Year
ds, P.	n signed by	۵	Part II. Other significant conditions con	tributing to death bu	t not resulting in th	e underlying	cause give	en in Part I.			bacco use con es 2□No	tribute to	the cause of death?
I Records, The law requires that has been signed	Completed								24a. Was a autops perform	sy	prior to c death?	topsy findings available ompletion of cause of 2 No	
f Vita	Vital slcian: certifice irector, p	To Be	25. Was case referred to medical examiner? 1 Yes 2 H	ospital:	nt 2 ☐ ER/Outpa	utient 3□ D	OA Othe			(Check only or e 5 ☐ Resid	ne) ence 6 □Ot	ner (Spec	ufy)
Of Phy raid		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	y 28b. Tim <i>Year)</i> Inju	e of ry M	28c. Injury Work	at (? Yes 2 □ N		3d. Describe h	ow injury occu	rred		
Divis	or Attendent death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc.						City or Tow	n, State)		ral Route Number,
Hosp	within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Cartifying Physics (Check only one) 2 Medical Examin		examination and/o								
Toth	withir To th	We	29b. Signature and title of certifier	sta		29	C. License	number 2 C	34		29d. Date signe	d (Month	2006
		ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	pe, Print)	LF	NAC	E .	BAUT	WIE	20	20215
1	Regist	rar	APR 0 6 20	06 Black	w 15. 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2 91200 /Medical ADRIVERSE SPIVEY 2006 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JUN 11, 1968 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 M 2 ZF 37 Yrs. Director Maryland 213- 94-1616 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show trsumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 2514 Park Heights Terrace 238 21215 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced Specify. "nstursi". Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental and Mental ဂ္ George T. Spivey-El, Jr. Pearl A. Witherspoon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health itsm 27 i 2514 Park Heights Terrace Pearl A. Spivey/Mother Baltimore, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of H Important: If Its any Injury or ot once. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/6/06 Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road Baltimore, MD 21228 21. Signature of Funeral Service Licensee
Licensel 4. Veg n cliff Edward A Gregorchik 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ysicien and e burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the b as

Be Completed by Physician/Medical signed by the at d be detached fo : After this certific tuneral director, Certification: To efter death.
I Director: Af

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)
Part II. Other significant condition	ns contributing to death but not resulting in	the underlying cause given in Part

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ast	Due to (or as a consec	quence of):									
pregnant months?] No	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 Ectopic							Date of de Month	elivery Day	Year
cant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc 1 Yes 24a. Was an										to the cau	se of death?
							24a. Was an autopsy performed?	1	death?	utopsy fir completion	ndings available on of cause of
ed to medical				26.	Place of De	ath (Check only one)				
No	Hospital:	ER/Outpatient 3 0	AOA	Other:	I ☐ Nursing	lome	5 Residence	6 🗆	Other (Spe	ecify)	
5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c.	Injury at Work? 1 Yes	2 🗆 No	280	d. Describe how inj	ury occ	curred		
6 Could not b	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ry, of	ffice		281	Location (Street a City or Town, Sta		mber or A	Tural Rout	e Number,
1@ Certifying Pt 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	datt n, in	he time, d my opinio	ate and plac n, death occ	e, and	d due to the cause(at the time, date a	s) and nd plac	manner a e, and du	s stated. e to the c	ause(s)

29d. Date signed (Month, Day, Year)

2006

April 5

Rear History

within 24 hours efter de To the Funeral Directo completely filled in by th

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 0 6 2006

Chi-cu

25. Was case referred to medical

29b. Signature and title of certifier

1 Yes 2 No

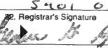
27. Manner of Death

1. Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier



010

029055

Reas

29c. License number

			For State Registrar	State of Ma		d / Depa	artmen		aith ai		ental Hy	giene	06	10736	
	100		Decedent's Name (First, Middle, Last)							2. Date of Dea	ath	V	3. Time ol Death	
W	Physicia		LORENZA CORNELIUS	SMALL							Month April	Day	Year 2006	3:30 p M	
	/Medic Examin		4a. Facility Name (If not institution, give		-		4b. City,	Town, or Lo	ocation of	Death			unty of Death		
	Examili	EI	325 Carroll Avenue	2			Lau	ırel				Pr	ince G	eorge's	
VA.	Funeral		Social Security Number 6. Se	x 7. Age	(In yrs. I	ast birthday)	II Under Months		f Under 2	4 Hrs. Min.	8. Date of Birt	h V Year)	9. Birth	nplace (State or Foreign untry) lorida	
.5)	Director		267-36-9318	ZM 2□F	70	Yrs.	Months	Days	Hours		(Month, Da Oct. 1	8, 19:	35 F	lorida	
	D.		Usual Residence of Decedent		40. 01	-								10d. Inside City Limits	
	show	_	10a. State 10b. County		10c. City	, Town or Lo	cation								
	e Ma	cto	MD Prince (George's	La	urel								1∏Yes 2∏No	
	or 2	Director	10e. Street and Number				10f. Zip					-	of What Co	untry?	
	23a	ra	325 Carroll Avenue				207						5.A.		
	teme	Funeral	11. Marital Status	 Was Decedent Farmed Forces? 		S 13.	Was Deced II Yes, spec	dent of Hisp cify Cuban,	Mexican,	Puerto F	cify Yes or No Rican, etc.)	14.	Race - Amer Black, White		
36	or i	by Fi	1 Never Married 2XXMarried 3 Widowed 4 Divorced	Armed Forces? 1XXYes 2 □ N If Yes, Give Year or Dates:	197		1 🗆 Yes	2 XX N0	Specify:			Sp	ecify: B.	lack	
21215-0036	within 72 hours after death with the Maryland sne. Than "natural", or iteme 23a or 28a-f show na Madical Examiliar i wat be notified at	De de	15. Decedent's Edi		17/		dent's Lisua	al Occupation	00			16b. Kind	ol Business/l	ndustry	
5	n 72	lete	(Specify only highest grad	ie completed)		(Give	kind of wo.	rk done dur	ring most	of workir	g		Gove		
12	withi ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5 4 years	+)	Tele	commu	nicat	ion	Spec	ialist	(Dep	ot. of	Justice)	
	filed Hygir other ent, II		17. Father's Name (First, Middle, Last)					1:	8. Mother	's Name	(First, Middle.	Maiden Su	mame)		
an	d be ental	o Be	Lefoy Butler Blille Mae Small												
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If it item 27 is marked other than "natural", or iteme 23a or 28a-f show or other treumatic event, It a Modical Examination and the notified at	F	19a. Informant's Name/Relationship (7	a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route No. 8043061 E. Kent Avenue Van.											
N	and 2 sealth ar in 27 is ner treu		David E. Small /	son	Vanco	uver,	B.C.	V554P5							
ē,	s 1 ar		20a. Method of Disposition		ate	20c. Loca	tion - City or	Town, State							
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 XX remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			_{emetery, cre} st Aru			1	4/6/	2006	Odei	nton.	Maryland	
Ħ	artme ortar injur		21. Signature of Funeral Service Licen:		1,10						lome, P			101-1	
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 it any injury or other tre		Maria Char	Od al M	10016	0 3	onald 13 Ta	ison E ilbott	uner : Ave	aı n	Laure	.A. l. Mai	cvland	20707	
			23a. Part1. Enter the disease, or comp shock, or heart lailure. List only of	lications that caused	the death								2	Approximate Interval Between	
*			shock, or heart failure. List only of Immediate Cause (Final											Onset and Death 6 months	
1	Physician /Medical		disease or condition resulting in death)	a. Gastri			ld ————							0 monens	
	Examiner			240 10 (0.45											
	*.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseq	uence ol):									
	uted d ansit	ᇤ	Cause (Disease or injury that initiated events	6											
Ć,	e be executed /sicien and e burial-transit	Examlner	resulting in death) Last	Due to (or as	a conseq	uence ol):									
760,	res thet the death certificate be executed igned by the ettending physicien and be detached for use as the burist-transit	cal	(d						_					
68	tificat g phy as th	led													
Вох	n cer endin use	N/u	23b. was decedent pregnant	23c. If yes, outcome 1□Live birth]Ectopic p	regrancy				230	d. Date of deli	•	
	deat	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (sp			-			Month	Day Year	
P.O.	by the	Physician/Med	9 🗆 Unknown	3E OIRIOWII											
Ś	requires thet the death certificat een signed by the ettending phy hould be detached for use as th	by	Part II. Other significant conditions of	entributing to death b	ut not res	ulting in the u	inderlying o	ause given	in Part I.					the cause of death?	
Records,	w require been sig should b	pe	Anemia								1 🗆	Yes 2 🔯	No 3 Pr	obably 4 Unknown	
သို့	S S S	ple									24a. Was auto	an :	24b. Were au	topsy lindings available completion of cause of	
	The law ate has b page 2 sl	Completed by									perfo	rmed?	death?		
ita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only	one)			
5	S S	To	1 ☐ Yes 2√2XNo	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatie			4 🗀 1401	rsing Hor	ne 5 💢 Kyesı	dence 6 [Other (Spec	cify)	
0 0	ng Ph fter th meral	ü	27. Manner of Death 1. XXI atural 5 ☐ Pending	28a. Date ol Inju (Month, Da	y Year)	28b. Time o Injury		28c. Injury a Work?			28d. Describe	how injury o	occurred		
Sio	endii eath. or: A he fu	atle	2 ☐ Accident investigation				М	1 □ Y∈	es 2 🗆 N						
Division of Vital	r Att ter de irect irect	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et			reet, factor	y, office		1		Street and I wn, State)	Vumber or Ru	ural Route Number,	
Ω	urs af	S								-					
	Hosp 4 hou Fune	ca	(Check only 2 Medical Exam	ysician: To the best liner: On the basis o	f examina	wledge, deal ation and/or in	th occurred rvestigation	at the time n, in my opii	nion, deat	d place, a th occurr	and due to the ed at the time,	date and p	nd manner as lace, and due	s stated. to the cause(s)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	one) 29b. Signature and title ol certifier	and manner st	ated.		20	c. License	number			29d. Date	signed (Mont	h, Day, Year)	
	T W I		255. Signature and the Of Certifier	1.40	K	Α -				-			,		
,	0		Belarm Wemreich MD D 28623 4/5/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
12	_ '		7 Man 2 . 0 A	completed cause of c	leath (Iter	n 23a) (Type	Print)	A	,	1 111	wel.	1 1 1	707.97	7	
			31. Date liled (Month, Day, Year)	32. P gistr	ar's Signa	EUITI.	MOYE	live	-	ull	WI CI	IVVD	2010	/	
	Sta Regist		APR 0 6	2006	was.	St A	COME								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 Randall Scott /Medical 4c County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner uare Hospita timore 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F Days Months Hours Min Yrs Director 406 15 1580 43 1963 Kentucky March 1. Usual Residence of Decedent 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits or 28a-f shov or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ➡No Director Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. "TA" 12 Parham Circle 21237 USA "natural", or iteme 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. important: if item 27 is marked other than "na eny injury or other traumatic event, Ing Media 2008. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Armored Car Company 12 operations manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Forb Flannery Scott Childers Grace Corrine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Parham Circle Apt "TA" Rosedale Md 21237 Diana Scott (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem Gardens 4/8/2006 Baltimore County, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sid eture of Feneral Service Lice 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern OAvenue Essex Marvland 21221 mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23a. Pert . Enter the disease, or c Approximate Interval Between Onset and Death Immedict Cause (Final disease of condition resulting death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, anding physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Dther (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No uneral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours after death To the Funeral Director: , completely filled in by the f To the Hospital Texture Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063974 ause of death (Item 23a) (Type, Print) 9000 Imran 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 6 2006 DHMH 17 Rev 1/2001

			1 - State Registrar Amend Item	State of Ma	-				Mental Hy	giene Reg. No.	006	10738
			1. Decedent's Name (First, Middle, La	ist)	city Go		/ 12/ VV JII		2. Date of De	eath Day	Year	3. Time of Death
	Physici: Medic/		JOSEPH '	FIMOTHY		SE	ERIO		APRIL	3,	2006	7:40 P. M
	Examin		4a. Facility Name (If not institution, given	e street and number)			4b. City, Town, or	Location of Death	h	4c. C	county of Death	
			66 JUMPERS CIRC				PERRY				BALTIM	ORE
F	uneral			Sex 7. Age 1∭3 M 2 ☐ F	(In yrs. last l		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Yea <i>r)</i>	9. Birth	place (State or Foreign intry)
Di	irector		216-24-9420 Usual Residence of Decedent	A	75	Yrs.			1/28/	1931	MA	RYLAND
and	* =		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
Many	f ehc	ŏ	MD BALTIM	ORE	PEF	RRY H	IALL					1 ☐ Yes 2 🕱 No
5	a or 28a-f show be notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	untry?
with	3a or		66 HIMDEDS CIDO	· E			21236			7	JSA	
deeth	E E	Funeral	66 JUMPERS CIRCI 11. Marital Status	12. Was Decedent E	ver in U.S.	13. \	Vas Decedent of His	spanic Origin? (S	pecify Yes or No		4. Race - Amer	
after	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N	0	1	Yes, specify Cubar		o Hican, etc.)		Black, White	, etc.
72 hours after deeth with the Maryland	Exp	d b	3 ☐ Widowed 4 🏋 Divorced	If Yes, Give Year or Dates:			I∐Yes 2∭X No	Specify:		8	Specify: W	HITE
72 h	disal	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16	(Give	lent's Usual Occupa kind of work done di	uring most of wor	rking	16b. Kind	d of Business/I	ndustry
within 90.9	r then the Me	ig m	Elementary/Secondary (0-12)	College (1-4or 5-	+)		00 NOT use retired) GER			CU1	IP REPA	TD
filled v	E .		7TH_GRADE 17. Father's Name (First, Middle, Las.			N.L.C		18. Mother's Nar	no (First Middle			IN
be f	d other	Be	IGNATIUS SERIO	,					STANCE I			
bluods	le markad other ther aumatic event, Italy	ဥ	19a. Informant's Name/Relationship	(Type Print)	10	Ob Mailin	g Address (Street a					in Code)
d 2 s th an	7 le trau		JOSEPHINE T. SER		,		HILLENDA					234
t end	Item 27 le marke other traumatic		20a. Method of Disposition	IO/SISIER	20b. Place	of Dispo	sition (Name of		Date		ation - City or 1	
Pages nent of	ant: If I		1				DRAL CEM.	4/6	/2006	BALT	TIMORE,	MD
permit.	Important: If Ite any Injury or of once.		21. Signiture of Funeral Service Lice	nsee Halka			Name and Address	1.1		SON FU		HOME, P.A. 1286
		-	23a Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on gad tin	the death. D			, such as cardiad	or respiratory a			Approximate Interval Between Onset and Death
	sician edical		disease or condition resulting in death)	a. Due to (or as	consequence	e of):	RECORD	CHUT	R			14140111)
Exa	miner	Ì				/-						
	-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	ce of):						
icate be executed	physicien and s the burial-transit	Examiner	triat initiated events	C								
, ×	urial-	Ä	resulting in death) Last	Due to (or as a	consequenc	e of):						
ateb	physic s the b	edical		d					·			
	ding b	Me	IF FEMALE:	22a If was autooms s	of programme.							
at a	ettending for use as	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 1	2 Fetal dea		Ectopic pregnancy			23	3d. Date of deli- Month	very Day Year
, g	the thed	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	ime or death	3	Other (specify)					
that	2 8		Part II. Other significant conditions	contributing to death bu	it not resulting	g in the u	nderlying cause give	n in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
The law requires that the death certi	n sign	ed by							10	Yes 2□	INO -XIPK	bably Mnknown
2 8	s been s 2 should	Completed							24a. Wa		24b. Were aut	opsy findings available
T Par	2 9	E							auto perf 1 ☐ Yes	ormed?	death?	ompletion of cause of 2 ☐ No
	certificete irector, pag	0	25. Was case referred to medical					26. Place of Dea				
ysic	.v. ⊕	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier	nt 2 ER/	Outpatien	t 3 DOA Othe	r. 4 ☐ Nursing H	lome 5 Res	idence 6	Other (Spec	ify)
Attending Physician:	After th funeral		27. Marmer of Death 1 ☑ Natural 5 ☐ Pending	28a. Oate of Injury (Month, Day	Year) 28t	. Time of Injury	28c. Injury Work		28d. Describe	how injury	occurred	
Attendi		cati	2 Accident investigation 3 Suicide 6 Could not to	20				′es 2 □No				
or At	I Direct	Certification	4 Homicide determined		iry - At home, :. <i>(Specify)</i>	farm, str	eet, factory, office			(Street and iwn, State)	Number or Ru	ral Route Number,
Hoepital	To the Funerel Director: completely filled in by the	edical (29a. Certifier Check only one) Certifying P	hysician: To the best of miner: On the basis of and manner state	examination .	lge, death and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occu	and due to the	cause(s) a	and manner as place, and due	stated. to the cause(s)
To the within 2	To the	Me	29b. Signature and title of certifier	1.01.		7	29 License	number 1	•	29d. Date	signed Month	, Day, Year)
	4		Shur	Jun.			900.	20149		4 4	1	
	31		30. Hame and Address of party of	Simpleted caused by	ath (II)	a) (Ty 3	32 10	WOON	CH	nn	54	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 200	15	r's Signature	Soc	N.					

		•	For Amend Items 1 - State Registrar Amend Item :	s Signer, Orthodoxy 131 147 Per FH G8	1,925 USE 154 GE1	Of Osto Jet 1	997/126/10 6 Death	e R	eg. No.	10739
	Discrete!		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	th Day Year	3. Time of Death
	Physici: /Medic		Kathleen Slenb	aker				04	03 2006	4:07 PM
	Examin		4a. Facility Name (If not institution, give Union Memorial Ho				Location of Death Baltimore	è	4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Se 217-16-4992 1	TM 200 C	. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept 17	, 1921 Vii	nplace (State or Foreign untry) Cginia
	pu k		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	cation				10d. Inside City Limits
	Maryla a-f sho	tor	Maryland N/A		Baltimo					MXYes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	untry?
	ath wi		1345 W. 41st Stre				211		USA	
920	72 hours after deeth with the Maryland natural', or Itama 23a or 28a-f ahow Itaal Examinar must be notified at	by Funeral	11. Marital Status 1 ☐Ñever Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
5	72 h	etec	15. Decedent's Edi (Specify only highest grad	ication le completed)	(Give	dent's Usual Occupa	turing most of works	ing	16b. Kind of Business/l	ndustry
2121	within 72 ho jiene. r than "natur the Medical"	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired memaker)		Own Hor	ne
פ	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)	
<u>yla</u>	should bent and Ment	인	Elzie Jackson Mcl				011ie (
Mar	12 a 2 a 2 a 2 a 2 a 2 a 2 a 2 a 2 a 2 a		19a. Informant's Name/Relationship (T) Clarence Slenbake	•					, City or Town, State, Z more, Mary	
Baltimore, Maryland 21215-0036	Pages 1 and ment of Heali ant: If itsm 2 ury or other		20a. Method of Disposition 1 ★ Burial 2 Cremation 3 ■ 4 ■ Donation 5 ■ Other (Specify,			Date	20c. Location - City or Elkridge, N	Town, State		
Baltii	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licens	Funeral	Home, Inc.	. 21211				
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea						Approximate Interval Between
i	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Due to (or as a conse	Organ quence of):	Failure				Onset and Death
	Examiner		Sequentially list conditions if any, leading to immediate	b. MRSA Due to (or as a conse	Pneumo	nia				10 days
I	cuted nd transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c. Ventiles	derine	lenez			MINE	1500
68760	ficate be executed g physicien and as the burial-transit	edicai Ex	resulting in death) Last	Due to (or as a conse	quen e of):	Ø:-	0	- NONE	D BY WEDICHT WINE	20 dage
	ing ph	Med	IF FEMALE:		SII			FEATURE APT		
P.O. Box	The law requires that the death certi tle has been signed by the ettending age 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)	CERT		23d. Date of deli Month	very Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions co			nderlying cause give	en in Part I.	23e. Did tot	bacco use contribute to es 2 DNo 3 □ Pro	the cause of death?
Division of Vital Records,		Completed			·			24a. Was a autops perform	med? prior to death?	topsy findings available completion of cause of
/ita	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	dosaitali		100	26. Place of Death			
o	Phys this ral dir	. To	1 Yes 2 No	1 V Inpatient 2	☐ ER/Outpatier 28b. Time of				ence 6 Other (Spec	ufy)
o	th. : After	tlon	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl	(? Yes 2 □ No	200. 20001100 110	ow inquiry document	
Divisi	of or Attending after death. Director: After d in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec		eet, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ral Route Number,
_	Hospite 4 hours Funerel	edical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my kn iner: On the basis of examin and manner stated.	nowledge, death nation and/or in	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Month	, Day, Year)
			> 5.6. Sarahli	M.D		AT 24	38946-F	-40	04/03/06	
	3		30. Name and address of person who of SHAHAB TOURSAU	ompleted cause of death (Ite AD Rottl Un	em 23a) (Type,	Print) Cemeral	Hospital	, MD	9d. Date signed <i>(Montl</i>	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 6 2006	32. Registrar's Sign	nature					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day STEEL MARGARET DOLORES **Physician** MARCH 31 2006 2:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CENTER TIMONIUM If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Months 1 □ M 2 😡 F 219-16-2912 Yrs 80 8-15-1925 MARÝLAND Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b County 10a State ral', or iteme 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√ No ROSEDALE Director BALTIMORE 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21237 U.S.A. 7903 MONTROSE AVENUE Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 22 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: ģ 3√2 Widowed 4 □ Divorced WHITE "natural" Completed other than "natur vent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental le marked FRANCES (GUMMER) PAZOUREK FRANCIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health a THOMAS STEEL/SON 7903 MONTROSE AVENUE ROSEDALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If its eny injury or ot once. 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-3-2006 GARDENS OF FAITH CEM BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 21237 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nodakins NOM. **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires thet the death certificate be executed burial-transit that initiated events resulting in death) Last ding physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 ☐ Yes : After this certifice e funeral director, f Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospite Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Tes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No I Director: A within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical sempletely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number imo MArch 31, 2006 125205 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St. Bolts. Md 2120x BMC :124 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2006 Registrar

			1 - For State Registrar	State of M		•	artmer	nt of H		ind Me	ental Hy	Reg. No.	UUL	5	10741	
	Dhysiai		1. Decedent's Name (First, Middle,	.ast)							Date of De Month	Day	/ Ye	er	3. Time of Death	
	Physici /Medio	al	Barbara Mae Su								March		2006		7:45 PM	Λ
	Examin	er	4a. Fecility Name (If not institution, g)				Location o	f Death			County of D Baltim			
-			14129 Old Hanor 5. Social Security Number 6		ge (In yrs. Ia	ast birthday)		r 1 Year	stown If Under:	24 Hrs.	8. Date of Bi (Month, D				ece (Stete or Foreig	חו
я	Funeral Director		216-56-6318	1□M 2∏F	76	Yrs.	Months	Days	Hours	Min.	Feb 13	, Yeer) , 19:	30 Ma	ary1	and	
	p ,		Usuel Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							10	Od. Inside City Limits	
	shov	5	MD Balti	mara		isters									1 ☐ Yes 2 📆 No	
,	the N	rect	10e. Street and Number	MOTE	I.C.	130013		p Code				10g. Cit	izen of Wha	t Coun	try?	_
:	be filed within 72 hours after death with the Maryland nat Hygiana. ed other than "natural", or items 23s or 28s-f show event, its Medical Examiner must be notified at	Completed by Funeral Director	14129 Old Hand	ver Road				21	.136				USA			
	daati	ner	11. Marital Status	12. Was Decedent		S. 13.	Was Dece	edent of Hi	ispanic Orig	gin? (Spec	cify Yes or N Rican, etc.)	0-	14. Race - A			
36	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give			1 ☐ Yes		Specify:				Specify:			
21215-0036	hours tural	q pa	3 Widowed 4 □ Divorced 15. Decedent's	Year or Dates:		16a. Dece	dent's Us	ual Occup	ation		_	16b. K	ind of Busin			_
15	nin 72 n na n na	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or	54)	(Give	kind of w	ork done d use retired	during most	t of workin	9				,	
212	d with	E OE	12	0		h	ouse	wife					own h	ome		
nd	be filed tal Hygi d other event, II	Be	17. Father's Name (First, Middle, La	st)							(First, Middle		Sumame)			
yla	2 should be f and Mantal h is marked of raumatic eve	은	George Swem	CT Crist		10h Maid		- (Ctront			n Cock		r Tours Sta	te Zin	Code	
	D = C =		19a. Informant's Name/Relationship Tim Sullivan/son								Reis					
<u>ق</u>	s 1 and 2 should f Haalth and Mar Item 27 is marke other traumatic		20a. Method of Disposition	1	20b. Pl	lace of Dispo	sition (Na	ame of	1		ate	,	ocation - Cit			
OE .	Pagas ant of nt: # I		1 Burial 2 Cremation 3 1 Donation 5 Other (Spe		7	эттөгөгү, ста	matory or	otrier prac								
Baltimore,	permit. Pagas 1 an Department of Haal Importent: if Item 2 any injury or other 20028.		21. Signature of Euneral Service Line Rome Ld S	wade, Mi	ector			Anat Anat		oard 21201	655 W	. Bal	Ltimor	e S	treet	
F	Physician		23a. Part 1. Boter the disease, or conshock, or heart failure. List or Immediate Cause (Finaf disease or condition resulting in death)	in plications that cause by one cause on each	line.	value				cardiac or	respiratory	arrest,			Approximate Interval Between Onset and Death	
760,	rate be executed Medical Examiner physician and physician and the prival-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a b	s a consequ	uence of).										
B.	that the death certificate be as ed by the attending physician detached for use as the burie	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗌 Fetal	death 3	⊒Ectopic ⊒ Other (s	pregnancy specify)	,				23d. Date o Month		ry Day Year	
	Se Co	d by P	Part If. Other significant condition	s contributing to death	but not resu	ulting in the u	ınderlying	cause giv	en in Part I.						e cause of death? ably 4 (1967)	n
Rec	alaw hasb la 2 si	ompiet					-8				24a. Wa auto pen 1 🗆 Yes	opsy formed?	prio	r to cor th?	psy findings available inpletion of cause of 2 ™6	0
Vital	ysician: The is certificata director, pag	Bec	25. Was case referred to medical examiner?					- 11-		of Death	(Check only	оле)				_
× ×	Physician: this certific al director,	ို	1 ☐ Yes 2 ☐ No			ER/Outpatie			4 🗆 140		ne 5 Res			Specify	')	
_	D 9 8	Certification:	27. Manner of Death t Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no		ay Year)	28b. Time of Injury	М		yat k? Yes 2 □	No	8d. Describe					
Divi	To the Hospital or Attendin within 24 hours after death. To the Funaral Director: Aft complataly filled in by the fun	Certific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place of II	njury - At ho etc. <i>(Specif</i>)	ome, farm, st	reet, facto	ry, office		2		(Street ar own, State		or Hura	I Route Number,	
	ne Hosp n 24 hou ne Funai	Medical		Physician: To the best caminer: On the basis and manner:	of examina							, date an	d place, and	due to	the cause(s)	
	To the To the comp	X	29b. Signature and title of certifier	MO			2		e number	2			te signed (f			
,			years	1.0				0	500.	45		ra	rch	14	2006	
			30. Name and address of person w	no completed cause of	death (Item	23a) (Type, Aprè	Print)		West	Minis	ita	M	0 21	157	2006	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	Are	2									

			State of Maryland / Department				10710		
		•	1- State Registrar/Amend Item #12 &15 Per Inf G894	rtitigate/ofDgath	Re	ng. No. UUD	10/42		
			Decedent's Name (First, Middle, Last)	2. Date of Deat Month	h Day Year	3. Time of Death			
	Physicia /Medic	al	Russell A. Sellman		March 7	·	2:50 PM M		
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deeth			
			Carroll Lutheran Village 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Westminster If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Carrol 9. Birth			
	Funeral Director		220-16-0397 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Months Days Hours Min.	Nov 5,	Year) Con 1923 Mar	nplace (Stete or Foreign intry) vland		
			Usuel Residence of Decedent				401111111111111111111111111111111111111		
	show	_	10a. State 10b. County 10c. City, Town or Low MD Carroll Westmin				10d. Inside City Limits 1 ☐ Yes 2√ No		
	8e-f	Director			1	Og. Citizen of What Co			
	a or		10e. Street and Number	10f. Zip Code	"		and y r		
	heath ns 23	Funeral	200 St. Luke Circle 11. Marital Status 12. Was Decedent Everin U.S. , 1, 13.	21158 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Amer			
(Q	after o	Ξ	Armed Forces MALL 2121—215	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White			
21215-0036	within 72 hours after death with the Maryland ene. Than "netural", or items 23e or 28e-f show he Modical Examiner must be nutified at	l by	1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes. Give Korea 51 - 52	1 ☐ Yes 2 ☑ No Specify:		Specify:whi	te		
5-0	72 h	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ring	16b. Kind of Business/l	ndustry		
121	within	dm	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)					
2	Hygi Hygi ther ant,		17. Father's Name (First, Middle, Last)	banking 18. Mother's Nam	e (First, Middle, M	<u>financial</u> Maiden Sumame)			
a		To Be	John B. Sellman	Hilda	Wertz				
Maryland			19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rur	The second second	City or Town, State, Z	ip Code)		
	27 mg			Weller Circle #10					
ore			20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	osition (Name of matory or other place)	Date	20c. Location - City or "	Town, State		
Ë	2 to 0 to 0		* 4 \(\times\) Donation 5 \(\times\) Other (Specify)						
Baltimore,	permit. Page Department of Important: If any injury or once.		1/22-1-1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	tate Anatomy Board		Baltimore	Street		
1	707 4 Q		22a Part v Enter the disease or complications that caused the death. Do not en	altimore, MD 2120		a et	Approximate		
1	Physician /Medical Examiner		shock, I heart failure. List only one cause on each line.	Name of the Name o	167 2 01 4.55		Interval Between Onset and Death		
			disease or condition resulting in death) a. Due to (or as a consequence of):	use Dementer	~ End	Stuze	éwiren		
24			aseun			1	Zer. Si cera		
44		Je	Sequentially list conditions. I any, loading to immodiate cause. Enter Underlying Cause (Disease or injury						
	ocuted nd transi	Examiner	that initiated events C.						
,092	ie be executed /sicien and e burial-transit		resulting in death) Last Due to (or as a consequence of):						
687	~ ~ ~	dical	d						
9 X 6	death certificate I e attending physi od for use as the b	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	verv		
Вох	death atter	clar	in the past 12 months? 1 Ves 2 MNo 4 Pregnant at time of death 5	Dectopic pregnancy Other (specify)		Month	Day Year		
0	that the de ed by the detached	hysi	9 Unknown						
S, D	The law requires that the ate has been signed by th bage 2 should be detache	by P	by P	oy P	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tob	pacco use contribute to	
ord	w require been si should b	ted	Moth Bysphane		1 🗆 Ye	es 2 /25∖ No 3 □ Pro	obably 4 Unknown		
Records,	has be ge 2 sh	ple	000		24a. Was a autops	y prior to d	topsy findings available completion of cause of		
= 3		Completed			perform 1 Tyes 2		2 No		
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Othor	th (Check only on		_		
of	Phys this al dir	7	1 Pes 2 No 1 Inpatient 2 ER/Outpatien 27. Magner of Death 28a. Date of Injury 28b. Time of	nt 3 DOA		ence 6 Other (Spec	ufy)		
	fter	ţ	1	Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred				
Division	Atten r deal sctor	ifica	3 ☐ Suicide 6 ☐ Could not be 28e Place of Injury - At home, farm, st	reet, factory, office		reet and Number or Ru	ral Route Number,		
Ö	s afte	Certification:	4 ☐ Homicide determined building, etc. (Specify)	1	City or Town	1, 31410)			
	To the Mospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Experimer: On the basis of examination agrees the control of the basis of examination agrees the control of the basis of examination agrees the control of the basis of examination agrees the control of the basis of examination agrees the control of the basis of the control of the basis of the control of the basis of the control of the basis of	n occurred at the time, date and place,	and due to the cared at the time. d	ause(s) and manner as	stated.		
	the H nin 24 the F nplete	Medical	one) and mander stated.						
	1 with 00	~	29b. Signature and title of certifier	29c. License number		9d. Date signed (Montl	i, bay, rear)		
		1	43141	113 विषय		Novoh 28	112006		
			30. Name and address of person who completed cause of death (Item 234) (Type	Print)	. C A-	-band in	in dus !		
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	was new	للسلاح سلا	N del W	est miles		
c.A.	Registr		APR 8 6 2006 Been Se						

		•	1 - For Stete Registrar	State of Maryland /		rtment of l				ene 0 0	6 107	43
			1. Decedent's Name (First, Middle, Last)						2. Date of Death Month	Day Ye	3. Time of	
	Physicia /Medic		Edward Vernon Sm	ith					March 27	, 2006	10:28	3 AMM
	Examin		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town,	or Location of	of Death		4c. County of		
			8255 Harmony Road			Denton		O.4 Usa		Caroli		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days		Min.	8. Date of Birth (Month, Day,)		Birthplace (State of Country)	
	Director		Usual Residence of Decedent	79	115.				Feb 26,	1927	Massachus	etts
	and w		10a. State 10b. County	10c. City, To	own or Lo	cation					10d. Inside C	ity Limits
	Mary f sho	ŏ	MD Carolin	Α	Den	ton					1 🗆 Yes	2 No
	288 288	Je C	10e. Street and Number			10f. Zip Code			109	g. Citizen of Wha	at Country?	
	3a or		8255 Harmony Road			21	629			USA		
	death ms 2	Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S. Amped Forces?	13.	Vas Decedent of Yes, specify Cub	Hispanic Ori	igin? (Spe	city Yes or No-		American Indian, White, etc.	
Q	or Ite		1 Never Married 2 Married	1 AYes 2 No		l ∏ Yes 2 🎇 No			riodii, oto.,		white	
5-0036	ral,	d by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates: 143-57								
2	be filed within 72 hours after death with the Maryland Hygiene. do other than "natural", or items 23a or 28a-f show adother than "natural", or items 23a or 28a-f show awent. Ite Moderal Examiner must be notilised at	Completed	15. Decedent's Educa (Specify only highest grade	ation 1 completed)	(Give	lent's Usual Occu kind of work done DO NOT use retire	during mos	t of worki		6b. Kind of Busir	iess/Industry	
2121	within ne. ihen	mp	Elementary/Secondary (0-12)	College (1-4or 5+)			,	1,,,		seafare	· ···· i on	
2	Hygie ther int.	ပ္ပ	12 17. Father's Name (First, Middle, Last)	V	рог	t repres			(First, Middle, Ma		: unron	
		Be c	Edward Vernon Smit	h Sr			Ма	rion	Horne			
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than "Iraumatic avent, the Mer	70	19a. Informant's Name/Relationship (Type		9b. Mailir	g Address (Stree			I Route Number,	City or Town, Sta	ate, Zip Code)	
<u>@</u>	od 2 ilth ar 27 is r trau		Edward C. Smith/son	n 8	3255	Harmony	Road	Dent	on, MD	21629		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic at <u>900.08</u> .		20a. Method of Disposition	ceme	of Dispo	sition (Name of natory or other pla	ace)		ate 2	0c. Location - Ci	ty or Town, State	
9	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☑ Donation 5 ☐ Other (Specify)	moval from State								
=	mit. I		21. Signature of Funeral Service Licenser RODALO W	ade. Marector	33	Name and Addr	ess of Facility	hard	655 W.	Baltimo:	re Street	
m	Depariment Deparement	1 1	1 10001111	MINER	Ba	altimore	• MD	2120	1			
П			23a. Part Enter the disease, dr complic shock or heart failure. List only one	ations that caused the death. It	Do not ent	er the mode of dy	ing, such as	cardiac o	or respiratory arres	st,	Approxima Interval Bel	tween
	Physician		Immediate Cause (Final disease or condition	Sudlan d	eal	6					Onset and	Death
	/Medical		resulting in death)	Due to (or as a consequen	ce of):						10-15-50	
7	Examiner		Sequentially list conditions, b.	rten Issen								
	D #	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cors- uen	ice of):							
	and trans	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last	ice of):								
8760,	death certificate be executed e attending physician and nd for use as the buriat-transit	E		Due to (or as a consequen		0						
87	physi the t	dicai	d.	- Byprcheles	HENN	esu						
9 X	that the death certifics ed by the attending ph detached for use as t	Physiclan/Med	IF FEMALE: 23	Sc. If yes, outcome of pregnancy	,					23d. Date	ol delivery	
Вох	atten for u	clan	in the past 12 months?	1 Live birth 2 ☐ Fetal de 4 Pregnant at time of deatl	ath 3[Ectopic pregnant Other (specify)	су			Month	*	Year
P.O.	the di y the ched	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown								
٦	that led b	by Pt	Part II. Other significant conditions cont	tributing to death but not resulting	ng in the u	nderlying cause g	iven in Part	l.	23e. Did toba	acco use contrib	ute to the cause of	death?
Vital Records,	w requires that s been signed t should be deta								1 ☐ Ye	s 2 No 3	☐ Probably 4 ☐]Unknown
Ö	w rec	Completed							24a. Was an	24b. We	ere autopsy findings or to completion of c	available
Be	he lav e has age 2	Juc							autopsy perform 1 Tes 2	ed? de	ath? ☑Yes 2☐ No	Jause of
ta	ician: Th certificate rector, pag	60	25. Was case referred to medical				26. Plac	e of Deat	h (Check only one			
<u> </u>	ysician: The Is certificate hadirector, page	To B	examiner?	ospital: 1 Inpatient 2 ER	/Outpatie	nt 3 DOA	ther: 4 N	ursing Ho	me 5 Nesider	nce 6 Other	(Specify)	
o c	무무물		27. Manner of Death	28a. Date of Injury (Month, Day Year)	b. Time o	f 28c. Inj	ury at ork?		28d. Describe ho	w injury occurred	1	
Division	ttending I death. ctor: After t the funer	Certification;	Natural 5 Pending 2 Accident Investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,]Yes 2□]No				
ivis	r Atte	tific	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, larm, st	reet, lactory, office	Э		281. Location (Str. City or Town,	eet and Number State)	or Rural Route Nur	nber,
	ital o rs aft ral Di											
	Hospi 4 hou Funer ely fill	edical	(Check only 2 Medical Examin	icien: To the best of my knowle er: On the basis of examination	dge, deat and/or in	h occurred at the vestigation, in my	time, date a opinion, de	nd place, ath occur	and due to the ca red at the time, da	use(s) and mana te and place, an	ner as stated. Id due to the cause((s)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medi	one)	and manner stated.			nse number				(Month, Day, Year)	
}	To cor	-	29b. Signature and title of certifier	1 _ =	0	200. 21001	000	1 112		2h 1.	1	
			1/1/	U M	7/	Print)	1610	159		2/20/6	U	
		and the same of th	30. Name and address of person who cor	mplered cause of death (Item 2)	sa) (Type,	// 14 C	1	12	MN	211	61	
10	C+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	e A	Men.		17	1.11/	0.0	V /	
	Regist		APR 0 6 2006	Bleden S.	1000							

State of Maryland / Department of Health and Mental Hygiene: For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** Kurt Karl Schoen 4:45 a.m. м March 26, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ellicott City Howard Ellicott City Health & Rehab Center 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** M 2□F Months Days Hours 356:10.336 Yrs. Director December 15, 1919 Germany Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be rotified at 1 Yes 2 No Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 U.S.A. 2510 Kensington Garden #303 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: WW □ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Government Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Specialist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Augusta Kompf Karl Schoen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum QDGS. 2510 Kensington Garden #303 Ellicott City, Maryland 21043 Son Mr. Stanley Schoen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State All County Cremation Services, Inc. 03/28/2006 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott Ci

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death mediate Cause (Final END Physician DENENTIA STAGE monuto disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DAYS ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of a attending physician and for use as the burial-transit D-SPHAGIA Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2/2 No spital or Attending Physician: Thours after death.
Ineral Director: After this certificate filled in by the funeral director, ps 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide within 24 hours a Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MARCH ZOOG Stople MD 00053150 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5017E110 SHAWNMACA GUPTA 9650 SANTIAGO COLUMBIA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0 6 2006

State Registrar

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a)
 Zabiullah Ali, M.D. Assistant Medical Examiner

APR 0 6 2006

32 Registrar's Signatur



O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 3, 2006

ORIGINAL

06-02326 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Tillman, Nancy 2006 10746 1- For State Certificate of Death Reg No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day April 4, 2006 17:12 **Medical Examiner** Nancy E. Tillman 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University Hospital **Baltimore City** n/a If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 6. Sex Country) Months Days Hours Min Director 213-40-2355 64 1 M 2 XF Sept. 22 1941 MD Usual Residence of Decedent H 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No 23a or 28a-f show notified at once. permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. White Hall MD Baltimore Director 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 19627 Graystone Rd. USA 21161 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: white 3 X Widowed Specify. ⋧ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) most of working life. DO NOT use retired) Itimore, MD 21215-0036 12 n/a BudgetAnalyzer Verizon Phone Co. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Dallas O. Renner Emma Mae Shock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဂ 19a. Informant's Name/Relationship (Type, Print) Charles W. Tillman, III 19627 Graystone Rd., White Hall, MD 21161 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4/8/06 Catonsville, MD Metro Crematory Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Ser Lemmon Funeral Home of Dulaney Valley, Inc. 23a. Part Enler the medase, or consilications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b. Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Physician/Medical UNPENDED AMENDED ending physician use as the burial The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant in the 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' 1 🗸 Yes 1 ✓ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other:

Nursing Home 5 Residence 6 Other: 1 Yes 2 No 28a. Date of Injury (Month, Day,Year) Apr 4, 2006 27. Manner of Death 2Bb. Time of Injury 2Bc. Injury at Work? 2Bd. Describe how injury occurred Certification: Driver auto auto collision 15:36 Natural 5 Pending 1 Yes 2 ✔ No Director: d in by the f 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be within 24 hours aft To the Funeral Di completely filled in or Town, State)
4207 Norrisville Road, Jarrettsville, Md. determined (Specify) Major Road / Highway 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) anature and title of certifier 29c. License number O.C.M.E. April 5, 2006 ame and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State Some Registrar APR 0 6 2006

ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

			For State Registrar	State of Maryl		artment of F rtificate of			jiene eg. No.	006	10747
H	Physici	an	Decedent's Name (First, Middle, Language) To a second secon					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	cal	Inze V.		S	4h City Town o	r Location of Deat	April 2)6 ounty of Death	11:15 A ^M
	Examin	ier	4a. Facility Name (If not institution, gi Bradford Oaks N				ir Location of Deat Lnton	n			
	-		5 Social Security Number 6.	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		9. Birth	George's place (State or Foreign
	Funeral Director		106-32-2417	1□M 20 F 80	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Feb. 2,	, Year) 1926	Vi	ntry) rginia
-	0		Usual Residence of Decedent				1				
	how		10a. State 10b. County		. City, Town or Lo	Clinton					10d. Inside City Limits 1 ☐ Yes 2\overline No
Ma	e Wa	Directo	Maryland Prince G	eorge s							
	vith th		10e. Street and Number	1		10f. Zip Code 20735		1		n of What Cou U.S.A.	intry?
	s 23g	Funeral	6902 Fulford St	12. Was Decedent Ever	in II S 12 1	Was Decedent of H		Specify Ves or No.		. Race - Ameri	can Indian
	ter de	-un	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No		f Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		Black, White	
	urs af	by	3/ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗖 No	Specify:		S	pecify:	erican
5	2 hou	ted	15. Decedent's E (Specify only highest g	Education	16a. Dece	dent's Usual Occup kind of work done	pation	rking	16b. Kind	of Business/Ir	
2000-01717	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	d)	, Amig	Ed	ation	
1	ed wi	Son	Ilth		Leaci	hers Aid		15			
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f ehow event, the Madical Examinar must be notified at	Be	17. Father's Name (First, Middle, Las				18. Mothers Na.	me <i>(First, Middl</i> e, Crut		ımame)	
y	should to ind Ment marke umatic	2	Willie Eva		10h Maille	an Address (Ctrast		ural Route Number		Tourn State 7	n Codel
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hydione. Depertment of Health and Mental Hydione. Bronstant: If time X7 is marked other than "natural; or items 23a or 28a-1 ehow any injury or other traumatic event, the Maralcal Examinar must be notified at another.		19a. Informant's Name/Relationship	· • ·	11	-		Clinton,			
ב כ	1 and Healt em 2		Barbara Jackson (Daughter)		esition (Name of matory or other pla		Date		tion - City or T	
Daltillore,	ages int of t: If it		1 ☐ 8urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Hemovai from State	cometery, crer Lee Crema		111Pr -		Clint	on, Ma	rvland
	nit. Pertme britan britan injuri	1 3	21. Signature of Funeral Service Lice				$^{-1}_{ m ess}$ of Facility $ m Le$	e Funera			
ם פ	Dep Aug		David how	l mooas7							n, MD 20735
			23a. Part1. Enter the disease, or con	mplications that caused the							Approximate Interval Between
	Physician		shock, or heart failure. List onlinediate Cause (Final	A 0150	zin sale	ruti: 1	femt ?	Diseane			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cor							
	Examiner		Sequentially list conditions								
	ם א	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	isequence of).							
4	cate be executed physicien and the burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last		pruence of):						
0000	cien a	9	Todaling in dodiny succ	Due to (or as a cor	Due to (or as a consequence of):					111	
ò	physi the t	dical		d							
<	certifi iding ise as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy							d. Date of deliv	verv
	atten	cian	23b. Was decedent pregnant in the past 12 months?	nant 1 live high 2 Fetal death 3 Fetonic pregnancy						Month Day	
į	The law requires thet the daath certifi ite has been signed by the attending i tage 2 should be detached for use as	Physician/M	1 □ Yes 2 1 No 9 □ Unknown	9□ Unknown							
Ľ	s thet ned b	by Pi	Part II. Other significant conditions	contributing to death but no	I resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	bacco use	contribute to	the cause of death?
3	w requires been sig should be	ba Ba						1 🗆 Y	es 2 🗡	No 3 ☐ Pro	bably 4 Unknown
necolus,	law re as bea 2 sho	Completed						24a. Was a autop		24b. Were aul	opsy findings available ompletion of cause of
č	The la cate has page 2	E						perfor	med?	death? 1 ☐ Yes	2 No
<u> </u>	ysician: Th is certificate director, pay	BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	ne)		
	d is	2	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatier	IL 3L DOA		Home 5 ☐ Resid			ify)
5	ding Pt h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Wo		28d. Describe h	ow injury	occurred	
200	Attending ir death. ector: After by the fune	cati	2 Accident investigation M 1 Yes 2 No						· · · · · · · · · · · · · · · · · · ·		
DIVISION OF	or Attendated detail	Certification;	3 Suicide 6 Could not 4 Homicide determine		At home, farm, str pecify)	reet, factory, office		City or Tow	n, State)	Number or Hu	ral Route Number,
2	ospital or Attend hours aftar death uneral Director: / iy filled in by the f		On Cartina Cartina	No. of the Control of	. ka awiladaa daab	5	ima data and plac	o and due to the			atata d
	To the Hospital or At within 24 hours aftar of To the Funeral Direct completely filled in by	edical		Physician: To the best of my aminer: On the basis of examiner and manner stated.							
	o the	Med	29b. Signature and title of certifier	(A.		29c. Licen	se number		29d. Date	signed (Month	, Day, Year)
	⊢≯⊢ŏ		I Noll	(mue)		חז	5206		Da	.13	2116
	.1		30. Name and address of person wh	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
	K		William Tanner,				101. Fort	Washino	ton.	MD 207	44
	St	ate	31. Dale filed (Month, Day, Year)	32. Registrar's S	Signature						
	Regist	rar	: APR 0 6 2	2006 1	M de	este					
DHI	MH 17 Rev 1/2	2001		and the second							

ORIGINAL

			1- For Amend Item State of Mar Registrar	yland/Depa erbal,0470	rtment of Health and M 16,06dhb, 6854 Illicate of Death	Mental Hygien Reg. N	e006	10748
			Decedent's Name (First, Middle, Last)			2. Date of Death Month D	ay Year	3. Time of Death
	Physici /Medic		MARSHALL		WIMBERLY	MARCH 23		13:35 M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death	4	c. County of Deat	h
			THE JOHNS HOPKINS HOS	PITAL	BALTIMORE CI	TY		
	Funeral			In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign
	Director		421 62 0207 XX ^{-M 2 - F}	58 ^{rs.}		Sept 30,		
	pur *		Usual Residence of Decedent 10a, State 10b, County 1	IOc. City, Town or Lo	cation			10d. Inside City Limits
	daryli	ö	Va Fairfax					1 ☐ Yes 2 ☐ No
	28a-1	Director	10e. Street and Number	Vienna	10f. Zip Code	10g C	citizen of What Co	X suntry?
	with with	<u>ā</u>	503 Hillcrest Circle S.V	[A]	22180			
	be filed within 72 hours after death with the Maryland ital Hyglene. id other then "natural", or Iteme 23a or 28a-f ehow event, the Medical Examinar must be notified at	Funeral	11. Marital Status 12. Was Decedent Ev				ited Sta	
	ter d	듄	Armed Forces?		Vas Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
2	hours after tural', or its	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes You No Specify:		Specify: W	hite
9500-61212	2 ho	ted	15. Decedent's Education	16a. Deced	ent's Usual Occupation	16b.	Kind of Business/	Industry
2	hin 7	ple	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1·4or 5+)	life. E	kind of work done during most of wor OO NOT use retired)	(ing		
	filed within 72 Hygiene. Wher then "nate" ont, the Medic	Completed	12 5		ician		ntertain	ment
and	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Maide	n Sumame)	
_	should be ind Mental marked o umatic eve	2	Marshall Norman Wimberly, S			n Woodum		
Mary	d 2 should th and Mer ?7 ie marke traumatic	17	19a. Informant's Name/Relationship (Type, Print)		g Address (Street and Number or Ru	-		
_	s 1 and f Health Itam 27 other tr		Virginia Wimberly (Wife)		Hillcrest Circle,			
Baltimore,	of H fitan		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place)	Date 20c.	Location - City or	Town, State
Ě	permit. Pages Depertment of I Important: If It eny Injury or o		4 ☐ Donation 5 ☐ Other (Specify)	Flint Hil	1 Cemetery March	28,_2006_0	akton, V	irginia
ä	permit. Depentimportal		21. Signature of Funeral Service Vicensee	22	. Name and Address of Facility Lee	Funeral H	ome,Inc.	6633 Old
11	70F 29		Mous N. Frank moods	57 A	lexandria Ferry R	oad, Clint	on, MD	20735
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not ente	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Pnysician	Q. 1	Immediate Cause (Final disease or condition	NSTROM'	S MACROSLOBU	LINEMIA		Onset and Death S
	/Medical			consequence of):				
	Examiner		Securetary list conditions.	RGILLOS	15			4 months
	P #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):				
	ecute and -trans	Cam	that initiated events c.	consequence of):		· · · · · · · · · · · · · · · · · · ·		•
Š.	cien s		Due to (of as a t	consequence or).				
9/8	icate be execute physicien and s the burial-trans	dical	d					
×	The law requires that the death certificate be executed ate been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	40	IF FEMALE: 23c. If yes, outcome of	preggancy			Dod Date of de	
ROX	atten for u	Physician/M	in the past 12 months?	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of del Month	Day Year
o	at the de by the s tached	ystc	1 Yes 2 No 9 Unknown 9 Unknown	no or doalir 5	(Specify)			
<u>.</u>	that t	モ	Part II. Other significant conditions contributing to death but	not resulting in the ur	iderlying cause given in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ď	w requires that been signed b should be deta	d by				1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Unknown
ö	v requ been shoul	Completed				24a. Was an	24h Ware 21	stones findings available
ĕ	The lav	m				autopsy performed?	death?	utopsy findings available completion of cause of
Vital Records,						1 Yes 2 □ N	lo 1 ☐ Yes	212 No
₹	stcien: certifice rector, p	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Mnpatient	•C.500	Othor	th (Check only one)	a /710# / /7	
	Phys raldi	. To	1 1 1 1 1 2 2 2 1 NO 1 2 Inpatient		1 3 DOA 4 Nuising H	ome 5 Residence		cify)
5	ding P. After fune	flon	1 Natural 5 Pending (Month, Day)	Year) Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No		,,	
Division of	deat deat ctor: y the	Certification;	3 Suicide 6 Could not be 28e Place of Injury	y - At home, farm, stre		28f. Location (Street	and Number or Ri	ural Route Number,
2	offer Direction	ert	4 Homicide determined building, etc.	(Specify)	,	City or Town, Sta		
	spita ours neral filled		29a. Certifier 1 Cartifying Physician: To the best of	my knowledge, death	occurred at the time, date and place	, and due to the cause	(s) and manner as	stated.
	24 the Full	Medical	(Check only 2 Madical Examinar: On the basis of e	xamination and/or inv	restigation, in my opinion, death occu	rred at the time, date a	nd place, and due	to the cause(s)
	To the Hospital or Attending Physicien: within 24 hours eller death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Mont	h, Day, Year)
)			Saufil Harley	27 M.D.	RES-OC	O MAD	CH 23,	2006
			30. Name and address of person who completed cause of dea			N-111K	-11 1000	2126+
	Ψ		MALLIK MAJMUDAR, MJ	THE JOH	NS HUPKINS HOSPITAL	bee NURTH WEL	FE STAGET O	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar	s Signature				
	Regist	ar	APR 0 6 2006 Blocker A	(Special				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH Daniel P Wertman 2006 7:27 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Baltimore Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 ☐ M 2 ☐ F Months September 18 1921 Middleport.PA Director 187 16 3321 Usual Residence of Decedent deeth with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County ir then "netural", or Iteme 23a or 28a-f ehow the Medical Exercitive must be notified at 1 Ves 2 No Baltimore City Baltimore Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6011 Plummer 21206 USA Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status Black, White, etc. f and 2 should be filed within 72 hours after theelth and Mental Hygiene.
Item 27 is marked other then "netural", or iten ther traumatic event, it a Modical Exertine. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√CXNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 NATool & Dye Maker Ray Machine Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Warren Wertman Carrie Reinhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Heelth a 7718 Sassagrass Way Severn, maryland 21144 David Farrell 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ŏ 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. April 6 2006 Baltimore Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home Inc 23a. Part. Enter the "flease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory artest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CEREBROVASCULAR ACCIDENT DAYS /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transit The law requires that the death certificate be executed UPPER GASTROINTESTINAL BLEEDING DAYS Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No death? is certificete h I director, page 2 X No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅙ 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA ctor: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funsrai Director: 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number ellos D 25886 Mara 2006 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LILIA CEBALLOS. M. D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10e.e.14.19a b 20a-c 22 per 1h g854 4-18-06 vt State of Maryland / Department of Flealth and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** March 2006 Mary Wildberger 1122 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner AGNES ORE HOSPITAL ITIY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. Sept 2, 19 6 Sax Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🂢 F Yrs. 213-72-3666 1958 Director Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at MD 1√ Yes 2 No Baltimore Direct 21223 121 Calhoun St. 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 3330 Wilkens Avenue 21229 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. **white** unk 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk s 1 end 2 should be filed within f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18, Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) Be ဂ 19a Informant's Name/Relationship (Type Print)

Mr. Herb Holliday (social Worker) Adult Protective Services 300 Metro Plaza

St. Agnes Hospital

Output

St. Agnes Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Peges 1
Department of H
Important: if Ite
eny Injury or ott 1 Surial 2 Cremation 3 Removal from State mel 4-20-06 Floseph Alwes Russy Funeral State Anatomy Board 535 4 □ Donation 5 ₩ Other (Specify) in state Mt. Carmel Dundalk, Md. Home P.A. Baltimore Street Baltimore, 21201 21216 2222 W. North Ave. MDApproximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acute Gastrointestinal Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (o. as a consequence of). Examine inding physicien and use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy certificete hes been signed by the atter rector, page 2 should be detached for u in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uriknown Huntingtons Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Carcinoma autonsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check on yone examiner' Hospital: 1 ☐ Inpatient R/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 2 No 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation efter death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide To the Hospitel of within 24 hours of To the Funerel D completely filled is Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner/stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 28, 2006 NO D&&53312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 900 Caton Arenue; Michelle Henggeler, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amenditem# 20b, per Fh. 0854, 477/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** APRIL 12:20 PM 2006 enead 2 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Hospita Union Memorial If Under 24 Hrs. Birthplace (State or Foreign (Country) If Under 1 Year Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 XE 93 217-16-3998 Yrs. 10-07-12 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location is 1 and 2 should be filed within 72 hours after deeth with the Marylar of Health and Mental Hygiene. It has not status to theme 23a or 28a-f show then 'ratural', or iteme 23a or 28a-f show other traumatic event, Ite Modical Examinant can be notified at 1 Yes 2 No Director MD. ltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0036 Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KNOC 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 3210 Walbrook Son Ave. Balto, Md. LTVIN Whilehead 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
eny injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. reenMoun 22. Name and Address of Eacility
JOSEPH L. RUSS
2222. CU. Nor Russ Funeral Home, P.A. North Avenue Bath N 21. Signature of Funeral Service Licenses Bath Md ZIZU 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEPTIC SHOCK HOURS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner HOURS DIBSTRUCTION BOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine sicien and s burial-transit CARDIO PULMONAR HOUR resulting in death) Last Due to (or as a consequence of): Box 68760, attending physicien I for use as the buria Physician/Medicai IF FEMALE: 23c. Il yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) signed by the at Id be deteched fo 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 3 Probably 4 ☐Unknown cete hes been signated to page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 21 No 1 Yes 2□ No 1 ☐ Yes Division of Vital Attending Physiclan: in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After t Certification: Injury 5 ☐ Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined 4 Homicide 6 filled Hospitel 1 Curtifying Physician: To the best of my knowledge, death occurred at the time, date and blace, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) ţ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 AT2438946F13 APRIL Z, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL IMENGAR KAVITA MD 2. Registrar's Signature 31. Date liled (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

APR 0 6 2006

			1 - For State Registrar	State of Ma		d / Depa	artmen	t of H	ealth a			jiene	000	1075	. 0
			Registrar 1. Decedent's Name (First, Middle, Last)			Cer	TITICAT	e or L	Death	1	2. Date of Dea	leg. No.	000	3. Time of E) ()
0	Physici /Medic	al	Paul W	illiam	Ar	nders,		T	. Landing a		March 2	3, Day		0600	М
*	Examin	er	4a. Facility Name (If not institution, give Citizens Care & Re	habilitat			4b. City,	Fre	deric	.k	0. Date (Birth		County of Dea	Freder	
	Funeral Director		227 22 0707 11		83	ast birthday) Yrs.	Months	Days	Hours	Min. D	8. Date of Birtl (Month, Day ecember	, Year)	1922	thplace (State or Marylar	rd
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Freder	ick	10c. City	, Town or Lo	cation	Fre	deric	k				10d. Inside City	
	h with th	ai Director	10e. Street and Number 123 East Eighth	Street,	Apt.	104	10f. Zip	Code 2	1701			10g. Citi	U.S.A.	ountry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avent, the Medical Examinar must be notified at ance.	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 N If Yes, Give Year or Dates:			Vas Deced f Yes, spec		ispanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi Specify:		
21215-0036	in 72 ho n "natur Nadical	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced (Give life. L	lent's Usua kind of wo DO NOT us	al Occupa rk done d se retired	ation during most	of working	g	16b. Ki	ind of Business	Industry	
d 212	filed with Hygiene ther the int, inc.	e Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	Conege (1-401 3-	-/	Route	Sale	smar		r's Name	(First, Middle,		erage (Company	
Maryland	ould be I Mental I wrked o	To Be	Harry Washington						Katie	Mae	Payne		· · · · · · · · · · · · · · · · · · ·		
	and 2 sh laith and 1 27 le m er traum		Paul M. Anders, Jr										g, MD 2		
Baltimore,	Pages 1: ment of He ant: If iten ury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Dogation 5 ☐ Other (Specify)	lemoval from State	Mt°	ace of Dispo metery, cren 011V	sition (Nar. natory of o e t Ce	ne of ther place Mete	ry M		27, 20		Frede	Town, State erick, MI)
Balt	permit. Departi Import any inj		21. Signaturi of Frineral Service Licens	9 111 . 12	reco	1021	Koo	nov	and B	lacto	rd Fune	ral	Home	, MD 217	7 01
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	645	Disea	er the mod	le of dyin	g, such as o	cardiac o	Tespiratory an	rest,		Approximate Interval Betw. Onset and De	een
8760,	icate be executed physician and s the burial-transit	lical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a Due to (or as a											
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pr Other (sp						23d. Date of de Month	elivery Day Ye	əa r
	quires that in signed b uld be deta	þ	Part II. Other significant conditions con	ntributing to death bu	it not resu	Iting in the ur	nderlying c	ause give	en in Part I.		23e. Did to		1	o the cause of de robably 4 Dur	
Division of Vital Records,	S C	Completed	Hypokalenia		_						24a. Was a autop perfor	sy	prior to death?	utopsy findings av completion of cau	vailable use of
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?								(Check only or				
on of \	Phy rald	tion; To	27. Manner of Death 1 Natural 5 Pending	lospital: 1 Inpatier 28a. Date of Injun (Month, Day	y	ER/Outpatien 28b. Time of Injury		8c. Injury Work	/ at	2	8d. Describe h		6 Other (Spery occurred	ecify)	
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc			eet, factor	y, office		2	8f. Location (S City or Tow	itreet an n, State	d Number or F	lural Route Numb	θ <i>Γ</i> ,
	Hospit	edicai (sician: To the best oner: On the basis of and manner state	examinati										
	To the within 2.	Me	29b. Signatur and title of certifier	0	1)	290	c. License	e number			29d. Dat	te signed (Mon	th, Day, Year)	
			· Cugene B. (asugu	nl			04	6307	W		23	MAR	06	
	O		30. Name and a dress of person who of Eugene B. Casa	agrande, M	1.D.,	1564		sumt	own P:	ike,	Freder	ick,	MD 21	702	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 4	32. Reoftra	r's Signat	ure A	Sperk	ري							

		1 - For Amend Item 2 Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland	54 ^D 64 Ce	7067068h rtificate of	ealth ar Death	nd Mental F		2006	3. Time of Death
Physic /Medi Exami	cal	IVORY Lee 4a. Facility Name (If not institution, give si	Blue		4b. City, Town, o	r Location of	Month March	23,	2006 County of Death	4:00 A M
Funeral Director	3.	Manor Care Ruxton 5. Social Security Number 6. Sex		ast birthday) Yrs.	Towson If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of (Month, May	Birth Day, Year,	Baltimon 9. Birth Con 33	re nplace (State or Foreign untry) LA
the Maryland 28e-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Baltimore 10e. Street and Number		tkvill				10a. C	itizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 No
iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Heelth and Mental Hygiene. If flem 27 is marked other than "natural", or items 23a or 28e-1 show or other traumatic event, the Medical Examiner must be notified at	by Funeral Dir	8905 C Waltham Wo	Dods Road 2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 2 No If Yes, Give Year or Dates:		21234 Was Decedent of Hif Yes, specify Cubi	dispanic Origi an, Mexican, Specity:	n? (Specify Yes or Puerto Rican, etc.	USA	14. Race - Amer Black, White	ncan Indian,
Mid y fall of L L 13-0000 d 2 should be filed within 72 hours af th and Mental Hyglene. ?? is marked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	of working		Kind of Business/	Industry
should be filed and Mental Hygins a marked other umatic event, it	To Be C	17. Father's Name (First, Middle, Last) Joseph Johnson 19a. Informant's Name/Relationship (Type	pe, Print)	19b. Maili	ing Address (Street	Mar	s Name (First, Mic y Clark or Rural Route Nu			Tip Code)
permit. Pages 1 and 2 Department of Heelth a important: If Item 27 is any injury or other tra		Dianne Lovick/Dau 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Ligense	emoval from State 20b. P	tace of Displemetery, cre eda To	osition (Name of matory or other pla wn Cemete 2. Name and Addre	ce)	Date 4-1-06 Winnfiel	Nat Nat	chitoche chitoche neral Ho	Town, State ES, LA me of
Priysician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Losper	-	atchitoche ater the mode of dyin	ng, such as c		ry arrest,		Approximate Interval Between Onset and Death
ate be executed hysicien and he burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Undertying Cause Cause	Due to (or as a consequence of the consequence of t							
that the death certificate be executed that the death certificate be executed ed by the attending physicien and detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of do	death 3	□Ectopic pregnanc □ Other (<i>specify</i>) _	y			23d. Date of del Month	ivery Day Year
The law requires that the ste has been signed by the bage 2 should be detached.	Þ	Part II. Other significant conditions con	stributing to death but not resi	ulting in the	underlying cause gr	ven in Part I.		Oid tobacco		the cause of death?
	Completed						1 Y	-	prior to death?	utopsy findings available completion of cause of 2 No
Attending Physician: Tr death. ector: After this certificete by the funeral director, pa	tlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 I No 27. Manner of eath 1 Varia 5 Pending investigation	lospital: 1 Inpatient 2 Inpat	ER/Outpatie 28b. Time Injury	of 28c. Inju	her: 4 Wur		Residence	6 □Other (Spe	cify)
DIVISION OF pital or Attending Phy urs after death. erel Director: After this liled in by the funeral of	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification To the best of my keep	y)			City o	r Town, Sta	ite)	ural Route Number,
To the Hospital or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral director.	Medical	29a. Certifier (Check crity one) 29b. Signature and title of certifier	sician: To the best of my knoner: On the basis of examina and manner stated.	tion and/or i	nvestigation, in my	opinion, death	h occurred at the ti	ime, date a	nd place, and due	e to the cause(s)
()		30. Nin e and address of person who	ted cause of death (Item	n 23a) (Type			Tows n	MM	-/	03/24/2006
S Regis	tate trar	31. Date filed (Month, Day, Year) APR 0 6 200	32 Registrar's Signa	iture	colis					

			1 - For State Registrar	State of Marylar		artment of tificate of		Mental Hy	giene Reg. No.	005	10755
9	Physici		Decedent's Name (First, Middle, Last) IRSELEEN	D	•	BOOKER		2. Date of De Month MARCH		2006 ^{Year}	3. Time of Death 9:00A M
	/Medi Examir		4a. Facility Name (If not institution, give s PRINCE GEORGE'S	HOSPITAL		CHEV	or Location of Dea		PR	County of Death	
-	Funeral Director		5. Social Security Number 6. Security Number 1 C C C C C C C C C C C C C C C C C C	7. Age (In yrs. 86	Yrs.	If Under 1 Yea Months Days			th ay, Year) 2 19		place (State or Foreign ntry) TH CAROLINA
and 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or itame 23a or 28a-f ehow with injury or other traumatic event, the Medical Examinar must be incliffed at once.	Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)	EORGE S LA E 12. Was Decedent Ever in U Armed Forces? 1 Yes, Give Year or Dates: cation	16a. Deced	Nas Decedent of Yes, specify Cu Yes 25 Notent's Usual Occurrence of Work don NOT use retired.	Hispanic Origin? (5 ban, Mexican, Puel o Specify: Ipation e during most of wo	to Rican, etc.) wrking me (First, Middle	U.S	zen of What Cou 5 . A . 14. Race - Americ Black, White, Specify: 17. Specify: 18. Specify: 19. Specify: 10. Specify: 10. Specify: 11. VATE	can Indian, etc. BLACK
altimore, Maryland	ages 1 and 2 should ont of Health and Mer it: if itam 27 is marke y or other traumatic	To	CLASHES DANIELS 19a. Informant's Name/Relationship (Ty, TERRI J. BOOKER/DA 20a. Method of Disposition 1 \(\times \) Burial 2 \(\times \) Cremation 3 \(\times \) R 4 \(\times \) Donation 5 \(\times \) Other (Specify)	AUGHTER 20b. F	15418 Place of Disposemetery, crem		t and Number or R K COURT B		ARYLA 20c. Loc		16 own, State
Baltir	permit. P Departme Importan any injuri		21. Signature of Funeral Service License		22	. Name and Add		J. B. JE	NKINS	S FUNERA	
8760,	Physician by Sicien and Physicien and Physician and Physic	dical Examiner	23a. Part1. Enter the disease, of complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect	wence of)	and a	man de cardia	and and a		pm	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certifica tie has been signed by the attending phoage? should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknowp	3c. If yes, outcome of pregns 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnand Other (specify)	ey .		2.	3d. Date of delive	ery Day Year
Records, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	derlying cause g	iven in Part I.	23e. Did t	1	/	he cause of death?
Vital Reco		Completed	25. Was case referred to medical	2				1 Yes	psy ormea? 2X No	24b. Were auto prior to co death? 1 \(\text{Yes}	psy findings available mpletion of cause of
Division of Vil	ding Phys	ation; To Be	examiner? 1 Yes 2 No H 27. Manyer of Death 1 Matural 5 Pending investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursing H	ath (Check only dome 5 Resi	dence 6		ý)
DIVI	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	cal Certification;	3 Suicide 4 Homicide 29a. Certifier (Check only) 3 Suicide 4 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	y)	occurred at the t	ume date and place	City or To	wn, State)	Number or Rura	hatad
)	To the H within 24 Complete	Medical	29b. Signature and title of certifier 30. Name and address of person who cou	and manner stated.	tion and/or inv	29c. Licen	se number	rred at the time,	date and	place, and due to	the cause(s)
	Sta Registr		JAMES CATEVENIS 1 31. Date filed (Month, Day, Year) MAR 2 3 2096	M.D. 3001 HOS Registrar's Signa	ture	ORIVE CH	EVERLY, N	1ARYLAND	207	785	

Please Type or Print in Black indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Lottie Μ. Bailey 21 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hartley H.
5. Social Security Number Hall 1006 Market Pocomoke
If Under 1 Year | If Under 24 Hrs. Worcester Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min Months Hours 1 ☐ M 2 🔀 F Director 7-26-1905 213-42-0485 Usual Residence of Decedent 100 Accomac Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or Items 23a or 28a-1 show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State rai', or itams 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director <u>Pocomoke</u> MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21851 Completed by Funeral 911 Clarke Ave 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give X
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 8TH Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ceselia Knight 2 Corbin Staurt Drummond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trau 2915 Stockton Rd. Poconicke, ND 218 5 1
sition (Name of Date 20c. Location - City or Town, State Paula Sparrow Grand-Daughter 2915 Sto

20a. Method of Disposition

1 Burial 2 GCremation 3 Removal from State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Pocomoke, MD. em 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fox Funeral Home Temperanceville, VA nea 23a Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Coronari disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 0 1 ☐ Yes 2 ☑ No 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred after death. I Diractor: After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 054422 ause i death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

1604 - Norke

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

2005

Pocomoke

MD 21851 (410-957-9488)

		·	For State Registrar	State of Maryla		irtment of F tificate of			jiene	16	10757
ľ į	Physici		Decedent's Name (First, Middle, La: Christine	e Evalina Brown				2. Date of Dea Month March 31	Day	Year	3. Time of Death 8:55 A M
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Deat			y of Death	
4		25 <u>-</u>	St. Mary's Nursing C			Leonardto			St. M		
	Funeral Director	883	5. Social Security Number 6. S 224-12-0385	THE OTTE	s. last birthday) 34 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day March 4,	1922	9. Birth Cou Virg	place (State or Foreign ntry) inia
	pu &		Usual Residence of Decedent 10a. State 10b. County	100.0	City, Town or Lo	cation					10d. Inside City Limits
	Manyla f sho	-0	Maryland St. Mary'		ollywood						1 ☐ Yes 2 🛣 No
	286-	Director	10e. Street and Number		011) 1100 0	10f. Zip Code			0g. Citizen of	What Cou	intry?
	h with		43245 Rosalinds Driv	e		20636			USA		
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Vas Decedent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		ce · Ameri	can Indian,
20	be filed within 72 hours after death with the Maryland that Hygiene. do other then "natural", or Items 23s or 28s-f show event, the Medical Examir at most be multipled at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2XXNo If Yes, Give Year or Dates:		□ Yes XX No	Specify:	,		^{ty} Blac	
9500-61212	tural	ed b	15. Decedent's E	ducation	16a. Deced	lent's Usual Occup	pation		16b. Kind of E		
ر 1	hin 72	piet	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done OO NOT use retire	during most of wo d)	rking			
	ygien ygien yer th	Completed	12		Но	nemaker			Own Ho		·
yland	m - 0 5	Be	17. Father's Name (First, Middle, Last,				18. Mother's Na	me (First, Middle,	Maiden Suma	me)	
Ĕ	2 should be and Mental Is marked (5	Charles S. Booker, 19a. Informant's Name/Relationship (19b Mailin	a Address (Street		ural Route Numbe	r. City or Town	State Zi	p Code)
Z	od 2 s lith an 27 is i		Diann Clark / Daught	**				dford, Vir	-		<i>p</i> 0000,
Ġ,	s 1 er if Hea item other		20a. Method of Disposition	206	Place of Dispo	sition (Name of		Date	20c. Location		own, State
Ē	Page nent o ent: If ury or		1 🌠 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State In Chr	urch Ceme	abaptist ^{pla} tery	^{ce)} ¦ Apri ∫5, 20		ing Will	Liam, V	/irginia
Baltimore,	permit. Pages 1 end 2 should be Department of Health and Menta Importent: If Item 27 Is marked eny injury or other treumatic es		21. Signature of Funeral Service Licer	nsee	M M	Name and Addre	ardiner Fu	neral Home	, P.A.	0	
	1-15	2 0	23a. Part1. Enter the disease, or com	plications that caused the de				own, Maryl			Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	TO I I	- In	Hr.	INR				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):	, ,	mentio				
	Examiner		Sequentially list conditions.	o End	Stagi	e de	meutio	1			
	pe jis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of): 1						
	xecut and al-tran	Examin	that initiated events resulting in death) Last	cDue to (or as a cons	equence of):						
8/eU	icate be executed physicien and the burial-transit	dical E	· ·	d							
٥	ruficat ng phy as th	Medi	IC ECMALE.								
ŏ	death certifi e attending id for use as	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	etal death 3□	Ectopic pregnanc	у			ate of deliv	ery Day Year
	it the death certifi by the attending tached for use as	Physician/Me	1 Yes 2 No 9 Unknown	4□Pregnant at time o: 9□Unknown	fdeath 5⊡	Other (specify) _	<u> </u>				Duy Tour
ב	that the		Part II. Other significant conditions of	contributing to death but not r	esulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use cor	ntribute to	the cause of death?
ds	quires n sign	d by						1 🗆 Y	es 2 No	3 ☐ Pro	bably 4 Unknown
Hecords,	The law requires that Ite has been signed b age 2 should be deta	Completed						24a. Was a		. Were aut	opsy findings available
	sician: The lav certificate has irector, page 2	E O						autop: perfor	med? 2 No	death?	ompletion of cause of
Vita	sian: ertifica ictor, j	Bec	25. Was case referred to medical examiner?	7			26. Place of De	ath (Check only or			
5	Physician: this certific rał director,	မ	1 ☐ Yes 2 📉 No		☐ ER/Outpatien	1 3LI DOA		lome 5 Resid			rfy)
	After	Certification:	27. Manner of Death 1 Natural 5 Pending Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wo M 1	ryat rk? Yes 2 ∐No	28d. Describe h	ow injury occu	irrea	
DIVISION	of attending after death. I Director: After din by the funer	ifica	3 Suicide 6 Could not b	e 28e. Place of Injury - At	home, farm, str					ber or Ru	ral Route Number,
É	Did or	Cert	4 Homicide determined	building, etc. (Spe	city)			City or Tow	n, State)		
	B T T P	edicai (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death	occurred at the ti vestigation, in my	me, date and place opinion, death occ	e, and due to the durred at the time, d	ause(s) and n late and place	nanner as , and due	stated. to the cause(s)
	To the Hos within 24 hi To the Fur completely	Me	29b. Signature and title of certifier	^		29c. Licens	se number	4	29d. Date sign	ed (Month	Day, Year)
)			- Asl	rah		D47066		1	March 31	, 2006	
			30. Name and address of person who	completed cause of death (It	em 23a) (Type,						
	***		A.D. Shah, M.D. St	. Mary's Medical		lding, Leor	ardtown, M	aryland 200	550		
	Sta Registi			32. Registrar's Sig	nature						
	** t		MAR 3 1 2	006 7							

Linda Lee Burch Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-02156 Amend Unpend item# 1,23a,27,28a-f penMF, 8854,4/19/06 TT Health and Mental Hygiene crn 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 12:05 P [™] Lynda Lee Burch 28 March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Leonardtown
If Under 1 Year If Under 24 Hrs. 20989 Winters Lane Mary's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🗓 F 50 Yrs. 215-70-9862 Director 12/8/1955 California Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or Items 23a or 28a-f shov the Madical Examiner must be notified at Yes 2□No **⊵**Maryland St. Mary's Leonardtown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20989 Winters Lane 20650 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 □ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 Grocery is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental h Kenneth Edward Bish Bonita M. Summerville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once. 27981 Cedar View Ct. Mechanicsville, MD. 20659 Kenneth Edward Bish / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Memorial 4 ☐ Donation 5 ☐ Other (Specify) 04/01/2006 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home PA. Kyle S. Simons M01206 22955 Hollywood Rd. Leonardtown, Maryland 20650 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Lamotrigine, Diphenhydramine, and alcohol intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day detached for Month Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ፩ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? dea h? 1 X Yes certificate 2□No 2□ No 1X Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1∭XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at Scene ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural Fnd 3/28/2006 Fnd 11:51a^M 1 ☐ Yes 2 No unk 2 Accident 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 20989 Winters Lane Leonardtown, MD 4 Thomicide House 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. March 29, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 ANA RNB10 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 3 1 2006

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Marylan	-	rtment of H			jiene 189. No	06	0759
	Physicia	an .	1. Decedent's Name (First, Middle, Last)	Be	11			2. Date of Dea Month	Day	Year	3. Time of Death 2:22 AM
	/Medic	al	BESSIE Mae 4a. Facility Name (If not institution, give st	<u> </u>	//	4b. City. Town, or	Location of Death	MARC	_	3, 2000 County of Death	2.CCA"
	Examin	er	11 1 11 11	rsing Home		Walker				ederick	<
	Funeral Director		201 20 0012	7. Age (In yrs.)	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day June 2	, Year)	reoun	elace (Stete or Foreign http) r t C G
	and ow		Usual Residence of Decedent 10a. State 10b. County	1 .	, Town or Loc	cation				1	0d. Inside City Limits
	Mary a-f sho	tor	Md. Freder	ick Fr	ederic	ck					1 Yes 2 □ No
	th with the 23a or 28 set by not	Funeral Director	10e. Street and Number 5783 Fringe Tre	ce Court		10f. Zip Code 21	703			en of What Cour	itry?
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Itams 23a or 28a-f show any injury or other traumatic event, It a Medical Examination ust by multified at once.	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	18	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)		4. Race - Americ Black, White, Specify: 34	etc.
2-0	72 ho	Completed by	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	ent's Usual Occup kind of work done	durina most of wor	king		d of Business/Ind	dustry Kome
121	within ene. than	Jupi	Elementary/Secondary (0-12)	College (1-4or 5+)	Nur	4	,		Fai	ility.	
מש	e filed Il Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)				^	ne (First, Middle,		Sumame)	
ylar	should be ind Mental marked o	To	George Be		-		Bessie	Sm			
Mar	d 2 sho th and 7 is m traum		19a. Informant's Name/Relationship (Type) DORIS MINOR	f - 1			and Number or Ru				
	is 1 and 2 of Health a ltem 27 is other trav		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name-of	1	Date		ation - City or To	
<u><u>E</u></u>	Page nent o ent: If ury or		Donation 5 ☐ Other (Specify)	emoval from State Be	echwo	od Cem.	March 30				
Baltimore,	permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other once.		21. Signature of Funeral Service Ligense	lins	61	Name and Addre	ss of Facility ROLINS	FUNCR	AC F.	no 21	101
	The same		23a. Par 1. Enter the disease, or complice shock, or heed failure. Let only on	ations that caused the death							Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq		sculon	Accord	ent			Horas
К	Examiner	Ļ	Sequentially list conditions, b	Due to (or as a conseq	uanca off:						
	ned insit	Examiner	Sequentially list conditions, if any, leading to immediate case of the conditions of the case (Disease or injury	Due to (or as a conseq	uerice orj.					_	
ó	cate be executed physician and the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	ate be shysici the bu	dicai	d								
9	leath certific attending p	/Me	IF FEMALE: 23	3c. If yes, outcome of pregna	ıncy				2	3d. Date of delive	ery
.O. Box	0 0 0	hysician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)	/			Month	Day Year
S, D	requires that the seen signed by th hould be detache	by Pl	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to			he cause of death?
Records	w require been si should b		Aspiration	preumonis	3	-		101	-		oably 4 □Unknown
3ec	e law has b	Completed	1	· · · · · · · · · · · · · · · · · · ·				24a. Was autop perfo	SV	prior to co death?	opsy findings available impletion of cause of
Vital	rician: The certificate harector, page	e Co	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only o	rmed? 2DX No	1 🗆 Yes	2 No
Į.	S 5	To B	avaminar?	ospital: 1 Inpatient 2 I	ER/Outpatien	t 3 DOA Ott	ac d	lome 5 ☐ Resid		□Other (Specif	5)
n of	Ing Phy Viter thi		27. Manner of Death 1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injui Wor	rk?	28d. Describe h	ow injury	occurred	
Division	Attending ir death. ector: Afte by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At he	ome farm str		Yes 2 □No	28f. Location (S	Street and	l Number or Rura	al Route Number,
Di≤	al or Attending Phy i after death. I Director: After thi d in by the funeral of	Certification;	4 ☐ Homicide determined	building, etc. (Specif	y)	501, Iddioly, 5.1150		City or Tov			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledicai C	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my known to the basis of examination and majner stated.	wledge, death tion and/or in	n occurred at the time stigation, in my o	me, date and place opinion, death occu	a, and due to the arred at the time,	cause(s) a date and	and manner as s place, and due to	tated. o the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier			29c. Licens				signed (Month,	
)	0)	>/-		Di	3091			3 23 0	6
1	5			and MD	8	Print) Tol	13091 L Han	se Aue	7	Freder	uch
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 4 2	32. Redistrar's Signa	ature #	have.					
DI	IMH 17 Rev 1/2		man ~ ± C	Julius .	No Vo						

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** A M 2006 March 22 8:03 Jeanne Μ. Breeden /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Northampton Nursing Center Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 ☑ F Yrs. 67 Dec. 15, 1938 Maryland Director 220-34-0417 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County r than "natural", or items 23s or 28s-f show tre Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7193 Peekskill Drive 21702 United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if itam 27 is marked other than "natural", or Itams 23s any injury or other traumatic event, tra Madical Exemples master. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 1 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government 12 Budget Analyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Lucille Garber John Howard Leroy Despeaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey L. Breeden / Husband Frederick, Maryland 21702 7193 Peekskill Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 27, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) 2006 Frederick, Maryland Resthaven Mem. Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician disease or condition resulting in death) Metastastic Kidner Carcenomo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ng physicien and as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9 Unknown ete has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2☑No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 1 ☐ Yes 2 ☐ No ဥ 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or At within 24 hours after d To the Funerei Direct 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number Shah Hiren 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederice Mo 32. Pigistrar's Signature Ih um as 31. Date filed (Month, Day, Year) State MAR 2 4 2006 Registrar

		_ For	State of Maryla				_	Are Legible	10761
	_	State Registrar		Ce	rtificate of	Death		eg. No.	1010.
Physicia	an	1. Decedent's Name (First, Middle, Last) Edward Harrison	Durne				2. Date of Dea Month	Day Yea	
/Medic	al	4a. Facility Name (If not institution, give s			4h City Town	or Location of Deal	MARCH	31 2001 4c. County of De	
Examin	er	THE MEMORIA	11	TAL		S TO/V		TALBO	
Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			hirthplace (State or Foreign Country)
Director		210 30 0003 11	M 2□F 79	Yrs.			7-23-1	926 St	.Michaels
land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10dMinde City Limits
Many a-f sh	tor	Md Talbot	St	. Mich	aels				1 ☐ Yes 2 🙀 No
ith the or 284	Direc	10e. Street and Number	-:++ D3 D	. O D	10f. Zip Code	2166		log. Citizen of What	Country?
ath w	ral	9220 Bozman-Neav				2166		USA	
ine, intally lated ZIZIO-000 stand 2 should be filed within 72 hours after death with the Maryland of theath and Mentel Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Exercities manted to redifficate the contract that the rediffication.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No Armed Forces: 1 Yes, Give Year or Dates:	rmv	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No		Specify Yes or No- to Rican, etc.)	Mhace Ar Black, Wi Mhaite	
72 ho	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of Busines	ss/Industry
vithin han "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire			a.16	. 1
Hygie ther t	e Co	11 years 1 17. Father's Name (First, Middle, Last)	year	Farm	er, Car		me (First, Middle,	<u>Self emp</u> Maiden Sumame)	oloyea
id be ental ked o	To Be	Ernest Harrison	Burns				Blades		
	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ing Address (Street	and Number or R	ural Route Number	r Sity or Town State	haels, Md.
and 2 and 2 salth a n 27 is		Esther A. Burns		9220	Bozman	-Neavit	t Rd. F	0. Box	21663
Datilings, Williams Permit. Pages 1 and 2 Deperment of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	amoval from State	cemetery, cre		ory 3-2	23-2006	Dover, I	De.
Danit. Depart Import		21. Signature of Funeral Service License	9 11 1	R R	2. Name and Addre	ess of Facility	ev Fune	eral Home	e, PC
		1. Cangoli			·· carro	'TT HULL	e g r arre		,
Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the de cause on each line.	eath. Do not en	ter the mode of dyn	ng, such as cardia	c or respiratory are		
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	cations that caused the die cause on each line. Due to (or as a cons	eath. Do not en		ng, such as cardia	c or respiratory are		Approximate Interval Between
/Medical Examiner	miner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	eath. Do not en	ter the mode of dyn	ng, such as cardia	c or respiratory are		Approximate Interval Between
/Medical Examiner	ai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	Due to (of as a con:	eath. Do not en	ter the mode of dyn	ng, such as cardia	c or respiratory are		Approximate Interval Between
/Medical Examiner	E	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con:	eath. Do not en	ter the mode of dyn	ng, such as cardia	c or respiratory are		Approximate Interval Between
/Medical Examiner	E	IF FEMALE:	Due to (or as a con:	eath. Do not en sequence of): sequence of): gnancy elal death 3[ter the mode of dyn	ng, 510 as earda	c or respiratory are		Approximate Interval Between Onset and Death Approximate Approximate Interval Between Onset and Death Approximate Approximate Interval Between Interval Be
/Medical Examiner	by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Jaquermaily list curtaitors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a constitution of present the but not to death but not tributing to death but not	eath. Do not the sequence of): sequence of): sequence of): gnancy retal death of death of death sequence of sequen	let the mode of dyn	ng, 5uch as eardia	23e. Did to	23d. Date of of Month	Approximate Interval Between Onset and Death
/Medical Examiner	by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a constitution of present the but not to death but not tributing to death but not	eath. Do not the sequence of): sequence of): sequence of): gnancy retal death of death of death sequence of sequen	let the mode of dyn	ng, 5uch as eardia	23e. Did to	23d. Date of o Month	delivery Day Year to the cause of death? Probably 4 □Unknown
/Medical Examiner	Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a cons Due to (or as a cons Due to (or as a cons Due to (or as a cons 1	eath. Do not the sequence of): sequence of): sequence of): gnancy retal death of death of death sequence of sequen	let the mode of dyn	y wen in Part I.	23e. Did to 1 4 24a. Was a autoppendor 1 Yes	23d. Date of of Month bacco use contribute es 2 No 3 an 24b. Were the prior the pri	delivery Day Probably 4 Unknown autopsy findings available o completion of cause of
/Medical Examiner	Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions.	Due to (or as a constitution of presental interpretation of the presentation of the pr	gnancy resulting in the u	Determine the mode of dyn	y ven in Part I. 26. Place of De	23e. Did to 1 Yes 24a. Was a autoppentor 1 Yes ath Check only or	23d. Date of of Month bacco use contribute les 2 2 No 3 an 24b. Were livior to death 2 2 No 1 Y	delivery Day Probably 4 Unknown autopsy findings available of completion of cause of each 2 2 140
/Medical Examiner	To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No No 25. Was case referred to medical examiner? 1 Yes 2 No No 27. Manner Death	Due to (or as a constitution of present the constitution of the co	eath. Do not the sequence of): sequence of): sequence of): gnancy retal death of dea	Ectopic pregnance Other (specify)	y ven in Part I. 26. Place of De	23e. Did to 1	23d. Date of of Month bacco use contribute es 2 No 3 an 24b. Were the prior the pri	delivery Day Probably 4 Unknown autopsy findings available of completion of cause of each 2 2 140
ng Physician: The law requires that the death certificate be executed managed that the certificate has been signed by the attending physician and mineral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Ex	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a constitution of presental interpretation of the presentation of the pr	eath. Do not the sequence of): sequence of): sequence of): gnancy retal death of dea	Ectopic pregnanc Other (specify) underlying cause gir at 3 DOA Other Wood	y ven in Part I. 26. Place of De	23e. Did to 1	23d. Date of of Month bacco use contribute less 2 2 No 3 1 an 24b. Were sy prior to death 2 2 No 1 1 Y ne) ence 6 0 Other (S)	delivery Day Probably 4 Unknown autopsy findings available of completion of cause of essential completion of cause of essential cause of essential cause of essential cause of essential essential cause of essential es
ng Physician: The law requires that the death certificate be executed managed that the certificate has been signed by the attending physician and mineral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con **Condition** 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 27. Manner eath 1 Natural 5 Pending	Due to (or as a constitution of present the constitution of the co	eath. Do not an acceptance of): sequence of): sequence of): gnancy etal death of dea	Determine the throughout the triangle of the throughout the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of the triangle of tr	y ven in Part I. 26. Place of De her: 4 \(\) Nursing y at rk?	23e. Did to 1	23d. Date of of Month bacco use contribute es 2 No 3 an 24b. Were sy brior 1 death 22 No 1 Y ence 6 Other (S) ow injury occurred	delivery Day Probably 4 Unknown autopsy findings available of completion of cause of essential completion of cause of essential cause of essential cause of essential cause of essential essential cause of essential es
ng Physician: The law requires that the death certificate be executed managed that the certificate has been signed by the attending physician and mineral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions. 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions conditions conditions conditions conditions.	Due to (or as a constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of th	eath. Do not end sequence of): sequence of): sequence of): gnancy setal death of dea	Diter the mode of dyn Diter the mode of dyn Diter the mode of dyn Diter (specify) Other (specify) Underlying cause grid and 3 DOA Other Do 28c. Inju Wo M 1 Coursed at the fit	y ven in Part I. 26. Place of De ner: 4 □ Nursing I ry at rk?]Yes: 2 □ No	23e. Did to 1	23d. Date of of Month bacco use contribute es 2 No 3 an 24b. Were sy med? death 2 No 1 Y ence 6 Other (S) ow injury occurred treet and Number or n, State)	Approximate Interval Between Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset O
ng Physician: The law requires that the death certificate be executed managed that the certificate has been signed by the attending physician and mineral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con examiner? 1 Yes 2 No No No No No No No	Due to (or as a constitution of the constituti	eath. Do not end sequence of): sequence of): sequence of): gnancy setal death of dea	Diter the mode of dyn Diter the mode of dyn Diter the mode of dyn Diter (specify) Other (specify) Underlying cause grid and 3 DOA Other Do 28c. Inju Wo M 1 Coursed at the fit	y ven in Part I. 26. Place of De her: ry at rk? JYes 2 _No me, date and plac opinion, death occopinion, death occopinion, death occopinion, death occopinion, death occopinion, death occopinion, second occopinion, death occopinion, death occopinion, second occopinion, death occo	23e. Did to 1	23d. Date of of Month bacco use contribute es 2 No 3 an 24b. Were sy med? death 2 No 1 Y ence 6 Other (S) ow injury occurred treet and Number or n, State)	delivery Day Year Into the cause of death? Probably 4 Unknown autopsy findings available o completion of cause of es 2 No Proportion of cause of es 2 No
Physician: The law requires that the death certificate be executed Tarthis certificate has been signed by the attending physicien and Injury at director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions condexaminer? 1 Yes 2 No 9 Unknown 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 26. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 27. Manney - eath 1 Natural 5 Pending investigation 6 Could not be determined	Due to (or as a constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of present the constitution of th	eath. Do not end sequence of): sequence of): sequence of): gnancy setal death of dea	Diter the mode of dyn Document y ven in Part I. 26. Place of De her: ry at rk? JYes 2 _No me, date and plac opinion, death occopinion, death occopinion, death occopinion, death occopinion, death occopinion, death occopinion, second occopinion, death occopinion, death occopinion, second occopinion, death occo	23e. Did to 1	23d. Date of of Month bacco use contribute es 2 No 3 an 24b. Were esy prior i death 22 No 1 Y ne) ence 6 Other (S) ow injury occurred treet and Number or n, State)	delivery Day Year In to the cause of death? Probably 4 Unknown autopsy findings available o completion of cause of pecify) Rural Route Number, as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval as stated. Interval Between Onset and Death State Stated. Interval Between Onset and Death State St	

State Registrar

20+1VA

Ludwid Eglseder, MD., 503 Cynwood Dr., Easton, Md. 21601
31. Date filed (Month, Day, Year)

MAR 2 3 2006

		1 - State of Maryland / Dep	partment of Health and Nertificate of Death		ene 06	0762
Physici /Medic		1. Decedent's Name (First, Middle, Last) Francis Herman Burch		2. Date of Death March 20	Day 0 0 6 Year	3. Time of Death 5:50AM M
Examin		4a. Facility Name (If not institution, give street and number) 1209 Brooke Rd.	4b. City, Town, or Location of Death Capital Height	s	4c. County of Death Prince Ge	eorges
Funeral Director		5. Social Security Number 577-54-7735 6. Sex 1 1 1 1 M 2 1 F 7. Age (In yrs. last birthday 65 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Sept. 20	ear) Cour	place (State or Foreign htry) Sh. DC
faryland ebow	ō	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Prince Georges Capital	ocation Heights		1	0d. Inside City Limits 1X Yes 2 □ No
r 28a-f	irect	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cour	ntry?
23a o	la D	1209 Brooke Rd.	20743		USA	
2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or Itams 23a or 28a-f show raumatic event. It is Modical Examinational be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Ammed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, 2 No If Yes, Give	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: B1	
thin 72 hou e. an "natura Moulcal E	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16	b. Kind of Business/In	dustry
led wil lygien her th			hanic		Self Emp.	loyed
ould be fil Mental H Narked otl	To Be	17. Father's Name (First, Middle, Last) Frank Burch	Daisy	e (First, Middle, Ma Proctor		
d 2 sh th and th and 17 ie m traum		1 1 1 1	ling Address (Street and Number or Rur Goodluck Rd. A		•	·
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natuu any injury or other traumatic event, II a Maciesal any injury or other traumatic		20a. Method of Disposition 20b. Place of Disp	position (Name of ematory or other place)	Date 20	c. Location - City or To	own, State
permit. Departm Importa any inju		21. Signaturs of Fluneral Service Licensee	22. Name and Address of Facility Adams Funeral Ho	ome, PA	20605 Aqu	uasco Rd.
Physician and phisician and phisician and phisician and the priid-transit	dicai Examiner	shock, or 'eart failure. List only 'ne cause neach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a conseque	sema failure.	ne		Interval Between Onset and Death
sath certific attending p for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	. /
rsician: The law rec s certilicate has bee lirector, page 2 shot	Completed			24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
ician: certific rector,	Be	25. Was case referred to medical examiner?		h (Check only one)	_	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	tion: To	1 Yes 2 Mo Noshida: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 Matural 5 Pending 2 Accident Injury 28a. Date of Injury 28b. Time Injury 28b. Time Injury 28b. Time 28b. Ti	The second secon	28d. Describe how		y)
tal or Attendi s after death. al Director: A ed in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
To T	2	29b. Signature and title of certifier Thoule	29c. License number 0.002/95	29d	Date signed (Month, $3-2/-$	
_12		30. Name and address of person who completed cause of death (Item 23a) (Type	a, Brint)			
70		Edward Mosley, MD - 10111 Woodl 31. Date filed (Month, Day, Year) 32. Afgistrar's Signature	aurel Way, Bowie	, MD 20	7-21	
Sta Registr		MAR 2. 3 2006	parte			

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day **Physician** 2300 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death me (If not institution, give street and number) Examiner If Under 24 Hrs. 8. If Under 1 Year Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours 1€M 2□ F Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours eftar deeth with the Maryland Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumstic avant the second s 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Hes 2 No Director 11 SOUCK SIOK 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 2 110 116 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ 110 δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-49/5+) Elementary/Secondary (0-12) s Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mariling Address (Smeet and Number or Rural Route Number, Lity or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, VERMONI 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/10/2004 4 Donation 5 Dother (Specify) Release to G. H.C 22. Name and Addre 21. Signature of Funeral Service Licensee 3001 HOSPITAL DRIVE, CHEVERLY, MD 20785 ods that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, age on each line. Enter the disease, or corr , or heart failure. List only Approximate Interval Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical re ma Examiner Due to (or as a consequence of): Examine ed by the attending physician end datached for use es the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 10 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Be Completed 27110 1 ☐ Yes 2 ☐ No 1 TYOU Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3□ DOA 27. Manne Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: At 2 Accident investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Medical 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. License number D0055135 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Ernest Adadevoh _Cheverly , MD. 20785 3001 Hospital Dr. 31. Date filed (Month, Day, Year) State 3 2006 Registra

			1 - For State Registrar	State of	Marylan		artment of rtificate of			lental Hy	giene Reg. No.	06	0764
	Physi	cian	1. Decedent's Name (First, Middle	, Last)						2. Date of De Month MARCH	Day 27,	Year	3. Time of Death
	/Med	dical	Leroy Crar 4a. Facility Name (If not institution	npton	harl		4b. City, Town,	or Location	of Dooth	MARCH		2006	12:25A.M.
	Exam	iner	Reeder's Memo		•			oonsbo				Vashing	nton
	Funera	1	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	r If Unde	r 24 Hrs.	8. Date of Bit	th		place (State or Foreign
	Directo		218-24-2043	1 X M 2□ F	77	Yrs.	Months Days	Hours	Min.	Jan. 13	1929	Ma	ryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						0d. Inside City Limits
7	Manyti f sho	ō		nington		Sha	arpsburg						1 ☐ Yes 2 🕍 No
ERGY	r 28a	Director	10e. Street and Number	111191011		- 0110	10f. Zip Code				10g. Citizen	of What Cour	ntry?
Ti)	th witl 23a o 25 be	aiD	3633 Harper's	Ferry Rd			2	1782				USA	-
7	r dea	Funeral	11. Marital Status	Amped For	dent Ever in U.	.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic O ban, Mexica	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	o- 14.	Race - Americ Black, White,	
>	36 rs afte	by Fi	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 🛱 Yes If Yes, Give Year or Da	_	951 - 953	1 ☐ Yes 2 🛣 No	Specify	y:		Spi	ecify: Wh	nite
0,	1215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be rectified at	ted	15. Decedent	's Education		16a. Dece	dent's Usual Occu	pation			16b. Kind o	of Business/Inc	
5	215 thin 7	Be Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	kind of work done DO NOT use retir	ed)		ang			
7	21 led wi lygien her th	Co	12	(1)		Patte	ern Shop			- (1711-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-			g Equipment
PRAMPTON	Maryland 21215-0036 to 2 should be filed within 72 hours aft than dealth 1919ene. 27 is marked other than "natural", or traumatic event, the Medical Exprintralments.	Be	17. Father's Name (First, Middle, Charles Crampt	,						e (First, Middle		name)	
CI	should Me mark	ပ	19a. Informant's Name/Relations			19b. Maili	ng Address (Stree			Mae Bu		wn, State, Zip	Code)
)	Me alth a strau		Altamae Crampto	on - Wife		3633	3 Harper	's Fer	ry R	d. Shar	psburg	,Maryl	and 21782
10	of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation	3 DRemoval from 9		lace of Dispo emetery, cre	osition (Name of matory or other pl.	ace)		Date	20c. Locati	on - City or To	own, State
W	Pag ment tant: I		' 4 □ Donation 5 □ Other (S	pecify)			Cemetery					burg,M	lary l and
NAME	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should ba filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be swifted at	DCB	21. Signature of Funeral Service	icensee //			3-15-00 PM			THE CHEST STREET			D 0470E
<		·	23a. art1. Enter the isease, or	complications that ca	aused the deat		25 S. Col ter the mode of dv		-			port,M	Approximate
	Dhuninin		shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ach line.	-	A						Interval Between Onset and Death
	Physicial /Medica		disease or condition resulting in death)	a. Arab.	or as a conseq	Annak ujence of):	con p	neces	mon	y			1 de
	Examine		Sequentially list conditions	b. den	phasia		·						/
	sit ad	lner	Sequentially list conditions, if arry, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	r as onseq	uence of):	_						
	xacute and Il-tran	Examiner	that initiated events resulting in death) Last	cDue to (oras a seq	uence of):	and in						
	vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be exacuted cleath. ector. After this certificate has baen signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit					,						1	
	687 tifficate g phy as the	Physician/Medical		0.									
	Box 68 leath certific rattending pl	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna		⊒Ectopic pregnan	cv			23d.	Date of delive	,
	e dea the att	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown		ant at time of d		Other (specify)	-,				Month	Day Year
	, P.O. Bc that the death ned by the atters detached for u	Phy	Part II. Other significant condition	– ens contributina to de	eath but not res	ulting in the u	ınderivina cause a	ven in Part	1.	23e. Did	tobacco use	contribute to the	ne cause of death?
	cords, w requires to baen signed should be detected.	d by				-	g caacc g			1 🗆	Yes 2□N	o 3□Prob	pably 4 Unknown
	w req	Completed								24a. Was		\$b. Were auto	psy findings available
	Re(The lavel the has bage 2	omp								auto perfo	psy ormed? 2 No	prior to condeath?	mpletion of cause of
	Vital Re siclan: The L certificate ha rector, page	Be C	25. Was case referred to medical examiner?					26. Plac	ce of Deat	h (Check only			
	of V hysic this ce	2	1 ☐ Yes 2 No			ER/Outpatie	IL 3 DOA		Tursing Ho	ome 5 Resi			iy)
	Jn C Jing P After	ilon:	27. Manner of Death 1 Natural 5 Pendin	9	of Injury h, Day Year)	28b. Time o Injury	W	uryat ork? ∐Yes 2□	∃No	28d. Describe	how injury oc	curred	
	Division of Vital Records, or attending Physician: The law requires that death. Director: After this certificate has baen signed in by the funeral director, page 2 should be of	ficat	2 Accident investig	not be 28e. Place	of Injury - At he	ome, farm, st	reet, factory, office					umber or Rura	al Route Number,
	Div	Certification:	4 Homicide determ	buildir	ng, etc. <i>(Specif</i>	y)				City or To	wn, State)		
	Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (g Physicien: To the Exeminer: On the ba and mann	sis of examina								
	To th withir To th	×	29b. Signature and title of certifie					nse number				gned (Month,	Day, Year)
			14				03	251	8		3/2	7/06	
	3H-5H		30. Name and address of person				Print) KEEDYSVI	115	MD 2	1756 3	01-432	-2222	
Q		State		22 0	enietrarie Signa	turo			110 6	1,00 0	102		
	Regi		31. Date filed (Month, Day, Year)	2006	Julian Signa	15. 19	nede						

			1 - State of Maryla Registrar		artment of H		d Menta	al Hygier	711116	10765
	Physici	an	Decedent's Name (First, Middle, Last)				Mo	te of Death	Day Year	
	/Medic		Robert Warring Carter 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of De	Ma eath		c. County of Dea	
	Examin	er	Fahrney Keedy Nursing Ho	me	0	boro			Nashing	
	Funeral		5. Social Security Number 6. Sex 7-Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 H		te of Birth onth, Day, Yea	9. Bii	httplece (State or Foreign
	Director		311-30-1303	90 Yrs.	World's Days	Hours W				irginia
	and		Usual Residence of Decedent 10a. State 10b. County 10c. 6	City, Town or Lo	cation					10d. Inside City Limits
	72 hours after death with the Maryland natural', or Items 23e or 28e-f show lical Examinat mutter notified at	ō	Maryland Washington	Smi+	hsburg					X□Yes 2□No
	r 28a	Directo	10e. Street and Number	SHILL	10f. Zip Code			10g. (Citizen of What C	Country?
	h with	0	33 Byron Drive		21	783			U.S.A.	
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin?	(Specify Ye	es or No-	14. Race - Am Black, Whi	encan Indian,
õ	or its		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Amed Forces? 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give 1938 Year or Dates: 958		1□Yes X□No	Specify:		,	Specify: W	
2-003e	ural',	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 358	150 Dece		ation		165	Kind of Business	
Ċ	in 72	ompleted	(Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of a	working	160.	Kind of business	windustry
77	iene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Mea	t Cutter			G	rocery S	tore
and	e filed within al Hygiene. I other than ' vent, I.e.Me	BeC	17. Father's Name (First, Middle, Last)			18. Mother's N	Name (First,	, Middle, Maide	en Sumame)	
<u>a</u>	should be nd Mental marked c	ToE	James Holt Carter			Marv	C. Bu	ırch		
a D	2 sho and I is ma eums		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or	Rural Rout	e Number, City	or Town, State,	Zip Code)
≥ ~`	of Health of Health if item 27 i		Nellie Romack Carter (wife)	33 1	Byron Dri sition (Name of	ve Smit	hsbur	g Mary	land 217	83
ore	Pages 1 nent of H int: If ite iry or oti		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren	natory or other plac	(8)				
	그 등 은 근	1	* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		el Cemete	_ <u>_</u>				Virginia
n n	Departiment of the policy of t		21. Signature of Funeral Service Licensee	22	. Name and Addres	ss of Facility	Dougl	as A. I	Fiery Fu	neral Home
u		-	23a. Part1. Enter the disease, or complications that caused the de	ath. Do not ent	331 Easte er the mode of dyin	rn Blvc g, such as card	N. diac or respi	Hagerst iratory arrest,	own Mar	yland 21742 Approximate
	Dhusisian		shock, or head/failure. List only one cause on each line. Immediate Cause (Final	1.						Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a cons	equence of):	me	mona				2 weeks
	Examiner		V	- 1 7.						
H	п ≓	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	equence of):						
	ecute and trans	Examiner	that initiated events c.							
8/60,	cate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a cons	aquerice or).						
280	death certificate e attending physi d for use as the	dical	d							
XOR	w requires that the death certific been signed by the attending p should be detached for use as	υ/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant						23d. Date of de	alivery
ň	death e atte d for	Icla	in the past 12 months?		Ectopic pregnancy Other (specify)				Month	Day Year
j.	requires that the een signed by th hould be detache	Physician/M	9 Unknown							
s,	es tha igned be de	by F	Part II. Other significant conditions contributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23			to the cause of death?
ecora	een s een s	ted					-	1 🗌 Yes	2 No 3 P	robably 4 Nunknown
ပ္	2 5 8	Completed					_ 24	4a. Was an autopsy performed?	prior to	autopsy findings available completion of cause of
VITAI H	Page at							☐ Yes 2001		s 2 No
=	ysiclen: is certific director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	Oth	er: A Salusain			6 □Other (Spe	aciful
Ö	ding Phy h. After this funeral d	-	27. Manner of Death 28a. Date of Injury	28b. Time of				escribe how in		вспу)
<u> </u>	ath. r: Afte	atio	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		k? Yes 2 □ No				
DIVISION	er de er de recto	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be building, etc. (Special Could not be building, etc. (Special Could not be building, etc.)	home, farm, str	eet, factory, office		28f. Lo	cation (Street ty or Town, Sta	and Number or F	Rural Route Number,
$\bar{\Box}$	pitel or Attenors after deat ours after deat lerel Director: filled in by the	O	3							
	HO HO Bly	edical	29a. Certifier (Check only one) (Check only one) (The Desire of Madical Examiner: On the basis of examiner) (Check only one)							
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. [Date signed (Mon	nth, Day, Year)
	- s = ō) mes		0	5232	.3	-	3/23/8	
			30. Name and address of person who completed cause of death (II	em 23a) (Type,						
34	9+1		Khalid Waseem 1126 Opal C	ourt t	lacersta	un m	D. 3	1740	!	
	Sta Registr		30. Name and address of person who completed cause of death (III Khali Jaseen 1260cl C 31. Date filed (Month, Day, Year) AR 27 2006 32. Begistrar's Sig	nature	arte					
				- /						

			1 - For State Registrar	State of Maryland	•		of Health a of Death		Reg	ene [] [] [] [] []	0766
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last) John Ma: 4a. Facility Name (If not institution, give s 22395 National C.	rio Caco	civio		wn, or Location o	M Death	Date of Death Month arch 29	Day Year , 2006 4c. County of Death St. Mary	
À	Funeral Director		5. Social Security Number 6. Sex			If Under 1		24 Hrs. 8.	Date of Birth (Month, Day, 1)	(ear) 9. Birth	place (State or Foreign intry) rict Columb
ore, Maryland 21215-0036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: if Item 27 is marked other than "natural", or iteme 23e or 28e-1 show yor other traumatic event, it is Madisal Exemination to an intilified at	To Be Completed by Funeral Director	10a. State Maryland St. Mary 10e. Street and Number 22395 National Ci 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	rcle 12. Was Decedent Ever in U.S Armed Forces? 1 Mayes 2 Mon If Yes, Give 1963 (cation e completed) College (1-4or 5+) Civio (pe, Print) Lvio-Jones	16a. Decedifie. I Retai 19b. Mailir 625	Ton Pan 10f. Zip Co 20 Was Deceder if Yes, specify 1 Yes 28 dent's Usual C kind of work of NOT use 1 Food	to de 653 It of Hispanic Orig Cuban, Mexican No Specify: Decupation done during most retired) 18. Mothe Vectoret and Numbe k Court, of place)	or's Name (F era M eror Rural F La P	y Yes or No- can, etc.) In the second of th	Oc. Location - City or T	ican Indian, , etc. ite industry ip Code) 20646 Town, State
8760, Baltimore,	The permit Department of the permit Department Depart	Ilcal Examiner	4 Donation 5 Other (Specify) 21. Signature of Paneral Service License Edward N. Brinsf 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Field Jr. M00 ications that caused the death ne cause on each line.	052 n. Do not ent	remator 2. Name and A	Address of Facility Leonal of dying, such as	y Brins ardtov cardiac or re	ofield in the state of the stat	harlotte H Funeral Hor yland, 206 st. acijac color do	me, P.A. 50 Approximate Interval Between
tal Records, P.O. Box 68	sician: The law requires that the death certifical certificate has been signed by the attending phylicector, page 2 should be detached for use as the	e Completed by Physician/Med	on the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions cor	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown ntributing to death but not resu	death 3	Ectopic preg	se given in Part I.		1 ☐ Yes 24a. Was an autopsy perform	24b. Were aut prior to c death? 1 No 1 Yes	Day Year
Division of Vital Records,	or Attending Phy tter death. Nrector: After this in by the funeral d	Certification: To B	examiner? 1	Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hobuilding, etc. (Specify	·)	M 28c	Other: 4 Nu Injury at Work? 1 Yes 2 I	rsing Home 28d No 28f	5 Resident Describe how for Location (Street, City or Town,	ice 6 Other (Special Indiana Special Indiana Special Indiana Special Indiana Special Indiana Special Indiana Special Indiana Indiana Indiana Indiana Indiana Indiana Indiana Indiana Indiana Indiana Indiana Indiana Indiana	ral Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Examinate) 29b. Signature and title of certifier 30. Name and address of person who co	ner: On the basis of examinat and manner stated.	1 23a) (Type,	29c. L Print)	my opinion, deal	th occurred	at the time, dat	d. Date signed (Month	to the cause(s)
	Sta Registi		William Boyd 11, 31. Date filed (Month, Day, Year) WAR 3 1 2	32. Refistrar's Signal	ture	_	Road, L	eonar	atown,	MD 20650	

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** March 30, 2006 7:50 A M James Raymond Curry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs. 59 Jan 24, Director 220-50-9052 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner rount by notified at 1 Yes 2 No Director St. Mary's Maryland Great Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 22162 Western Branch Road 20634 USA or Items 23a death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Mudical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Colfege (1-4or 5+) Elementary/Secondary (0-12) Disabled 8 N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any injury or other traumatic event SDRS. Be James Gregory Curry, Sr. Mabel Ann Tippett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22295 Gore Street Leonardtown MD 20650 James Gregory Curry, Jr. / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens Apr 3, 2006 Leonardtown, MD 21. Si maturo of Funeral Service Licensee, 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270, Leonardtown, MD 20650 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 140 card Immediate Cause (Final **Physician** disease or condition resulting in death) 4 our /Medical Due to (of as a consequence of) Examiner Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The taw requires that the death certificate be executed ding physicien and resulting in death) Last Due to (or as a consequence of). P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant signed by the atten d be detached for u 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 1 N or Attending Physician: ieral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ №6 2 CEN/Outpatient ဥ 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Alaturat 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ed. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number use of death (Item 23a) (Type, Print) 31. Date filed (2. Registrar's Signature State Registrar

ARAS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death p 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year RUSSELL HAROLD COOK, SR. MARCH 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keninsula gional medical Center Salista WILDMICO If Under 24 Hrs. If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1**★** M 2□ F Months Hours JULY 14, 146-03-7219 90 1915 **NEW JERSEY** Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow r than "naturel", or iteme 23a or 28a-f ehov the Medical Examiner must be notified at Yes 2 No Director EASTON MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 708 WAYSIDE AVE. 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 PRODUCTION MANAGER MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be f h and Mental I JOSEPH COOK PHOEBE MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and 2 ment of Health a ant: If Item 27 is 4906 DAWSON'S WAY ELLICOTT CITY, MD 21043 RUSSELL H. COOK, JR./SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Depertment Inportant: If any injury or CHESAPEAKE CREMATION CTR 3/24/2006 STEVENSVILLE, MD permit. 21. Signature of Funeral Service Licensee EASTON, MD 21601 HOME PA JOHN R. MERCE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Myolovo Physician /Medical Examiner Orlow Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical for use as the attending IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ۵ Records. 3 ☐ Probably 4 ☐ Unknown cete has been signated by page 2 should by 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has Division of Vital 1 Yes 2 **N**O 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dir Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0032212 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEIM, 106 MILFOYD STE 405 STEPHEN MD 31. Date filed (Month, Day, Yea 32. Register's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** EUGENE N. CHEEZUM MARCH 2006 10:37PM M 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HAVEN NURSING HOME CATONSVILLE BALTIMORE 7. Age (In yrs. last birthday)
74 Yrs. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year DEC 1 1931 5. Social Security Number 9. Birthplace (State or Foreign Funeral **X**□M 2□F 214-28-3234 MARYLAND Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be modified at 1 Yes 2 No Director MD CAROLINE PRESTON 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 4980 BETHLEHEM ROAD 21655 USA death Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after v Health and Mental Hygiene. em 27 Is marked other than "naturel", or Iter 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify: \$ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REPAIRMAN SMALL ENGINE REPAIR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM W. CHEEZUM WILHEMINA FISHER ပ permit. Pages 1 and 2.
Department of Health an.
Important: if item 27 is m.
any injury or other:
ODGS. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4980 BETHLEHEM ROAD, PRESTON, MD 21655 KAY F. CHEEZUM/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) MD VETERANS CEMETERY 3/21/2006 HURLOCK, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA . MERCERO MOHO 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ATHEROSCLEROTIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atten detached for u 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobecco use contribute to the cause of death? ģ þ DISCHSE 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 2□ No certificate 1 ☐ Yes 1 Yes **2**D Hospitel or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 ☐ No Nursing Home 5 Residence 6 Other (Specify) 2 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D28395

Registrar DHMH 17 Rev 1/2001

State

ueu

INCEN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

HATIVI

32. Regimar's Signature

7220

N/1 21208

			1 - For State Registrar	ate of Marylan		ment of He			giene 06	10770
	Physici	an	1. Decedent's Name (First, Middle, Last)	٥	Cevi			2. Date of Dea Month	th Day Year	A 5 Comm 100 110
	/Medio		4a. Facility Name (If not institution, give street			. City, Town, or	Location of Death		4c. County of De	
7	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday) If	Under 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March 1	, Year) (irthplace (State or Foreign Country) Maryland
	Maryland f show	tor	10a. State 10b. County Maryland Harford	10c. City	, Town or Location	Darli	naton			10d. Inside City Limits 1 ☐ Yes 2 XNo
	with the	Director	10e. Street and Number 3204 Cedar Chi	urch Pood	1	Of. Zip Code		1	0g. Citizen of What 0	
9	be filed within 72 hours alter death with the Maryland tal Hygiene. od other then "natural" or itema 23a or 28e-1 show event, the Madical Exeminar must be routiled at	Funeral	11. Marital Status 12. W A 1 □ Never Married 2 1 Married 1	/as Decedent Ever in U. med Forces?	If Yes	Decedent of His s, specify Cubar	21034 panic Origin? (Sp , Mexican, Puerto	pecify Yes or No- Rican, etc.)	Black, Wh	nencan Indian, nite, etc.
Maryland 21215-0036	72 hours a "natural", o	eted by	3 Widowed 4 Divorced IT 15. Decedent's Education (Specify only highest grade com	Yes, Give ear or Dates: 1952– opleted)	16a. Decedent (Give kind	of work done du	Specify: tion uring most of work	king	Specify:	Black
2121	e filed within at Hygiene. other then "	Completed	12	ollege (1-4or 5+)	life. DO N	t Mechai	nic		US Govern	nment
yland	2 should be fil and Menta! H is marked off eumafic even	To Be	17. Father's Name (First, Middle, Last) John William Cevis				Mary E	thel Wal		
	カケトコ		19a. Informant's Name/Relationship (Type, P Irvin Cevis / brothe	er	3206	Cedar (Church Ro	oad, Dar	, City or Town, State, lington, M	
Baltimore,	permit. Pages 1 and Deportment of Healt Important; if Item 2 any njury or other once.		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	ral from State	lace of Disposition emetery, cremator James U	ry or other place) {	/30/06	20c. Location - City o Darlingt	or Town, State
Balt	permit. Pa Depurtmen Important: any njury once.		21. Signature of Funeral Service Licensee	tt	22. Na L 5.	me and Address isa Scot 52 Lewis	of Facility Et Funera S Street	al Home, Havre	P.A. de Grace,	MD 21078
a ga	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Final disease or condition a.	ns that caused the death use on each line.	Do not enter th	e mode of dying	, such as cardiac	or respiratory arri	est,	Approximate Interval Between Onset and Death
8760,	Examiner bhysician and the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence to	Arter of):	terz	Di s eu 5	٤.		5 years
P.O. Box 6	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	Physician/Med	in the past 12 months?	yes, outcome of pregnar □Live birth 2 □ Fetal □Pregnant at time of de □ Unknown	death 3 □Ecto	opic pregnancy er (specify)			23d. Date of de Month	elivery Day Year
ords, P	equires that en signed b ould be deta	þ	Part 11. Other significant conditions contribute Dicheles, Rev		1 1	ying cause giver				to the cause of death? Probably 4 □Unknown
Division of Vital Records,	: The law require cete has been sig , page 2 should b	Completed						24a. Whas an autops perform	y prior to	
.≅ 	ilcian certiti rector	Be	25. Was case referred to medical examiner?	a)·				h (Check only on		
ion of	To the Hospitel or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certiticate ha completely filled in by the tuneral director, page	tion: To	1 165 29 140	1 npatient 2 L	ER/Outpatient 3 28b. Time of Injury	DOA Other 28c. Injury : Work?	4 LINUISING NO		ince 6 □Other (Spi w injury occurred	ecify)
Divis	el or Attendi s atter death at Director: A ad in by the to	Certification:	3 Suicide 6 Could not be	e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, f	actory, office		28f. Location (St. City or Town	reet and Number or F , State)	Rural Route Number,
	To the Hospitel or A within 24 hours atter To the Funeral Directorpletely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Call one)	To the best of my know on the basis of examinati and manner stated.	vledge, death occion and/or investig	urred at the time gation, in my opi	, date and place, nion, death occurr	and due to the ca red at the time, da	use(s) and manner a ate and place, and du	is stated. le to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	12/ 100	2	29c. License			9d. Date signed (Mon	
2	+IVA		30. Name and address of person who complete	ed cause of death (Item	23a) (Type, Print) 1778	57-1	7	Man 23 and, 212	5,2006
	Sta	te ·	Ano Treakle, 22 So 31. Date filed (Month, Day, Year)	32. Registrar's Signar	e Stree	+, Ba	Himore,	Maryle	ind, 212	01
	Registr		MAR 2 7 2006 Hear	with do	well			0		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Dev Franklin Dwight Custer 25, March 2006 3:30 AM4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Garrett Memorial Hospital 0akland Garrett If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Days Months 1 □ M 2 □ F Yrs. 380-18-4322 85 WV 21, 1920 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Garrett 0akland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1100 Alexander Lane 21550 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 IXYes 2 □ No if Yes, Give Year or Dates: WWII 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Doctor Veterinary Medicine 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Hale Gilmore Custer Mary Belle Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Lorena Custer 1100 Alexander Lane, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Memorial Gardens 3/29/06 Oakland, MD 22. Name end Address of Facility Burdock-Durst Funeral Home 21. Signature of Funeral Service License 21 N. Second St., Oakland, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate val Ret Onset and Death Immediate Cause (Final disease or condition resulting in deeth) DNeumon Due to (or as a consequence of) Due to (or es e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 2 40 3 Probably 4 Unknown 24

Physician /Medical Examiner

Department of Important: If any Injury or

Physician

/Medical

Examiner

10a. Stete

MD

Director

Funeral

δ

Completed

Be

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mental hygiene.
ant: If Item 27 is marked other than "natural", or thems 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notitled at

Baltimore, Maryland 21215-0036

ed other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at

Physician/Medical Examiner attending physician and I for use as the burial-transit been signed by the s should be datached Completed has Aftar this certificata B 2 Certification: aftar death.

I Director: Aft din by the fur

2

Medical

law requires that the death certificate be executed

or Attending Physician: after death.

Mospital of 24 hours a Funeral D

To the Vithin 2

15+VA

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated exercises resulting in death) Last Diahetes

Transversemyletis

i. Wes an autopsy performed?	24b. Were autopsy finding available prior to completion of cause of deeth?
1 ☐ Yes No	1 ☐ Yes 2 ☐ No

25. Wes case referre examiner?	d to medical
1 Yes 2	
27. Menner of Death	
1 Natural	5 Pending investigation
2 Accident	investigetion

lospitel: 1 Inpatient	2 ER/Outpatient
28e. Date of Injury (Month, Dey Ye	

2	Place of De	ath (Ch	eck only (эле,
er:	4 Nursing I	Home	5 🗆 Resi	den
v at		28d.	Describe	hov

1 🗆 Yes	2 🗆 No

1 Natural	5 Pending
2 Accident	investigetion
3 Suicide	6 Could not be determined
4 CT Upon Intale	getermined

286	Month (Month	n Dey	Year

	28c. Injury at Work?	
Λ	1 Tes	2 🗆 No

Oth

3 DOA

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

Н	ome	5 Residence	6	☐Other (Specify)
	28d.	Describe how inj	ury	occurred

200	Cartifica
29a.	Certifier
	(Check only

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location City or To	(Street and own, Stete)	Number	or Rurel	Route	Numbe

	one)	د اـــ
001	0'	 4241 -

4 - Homicide

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Yeer)

H26154

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Daniel Miller, 69 Wolf Acres Drive, Oakland, MD 21550 Dr. P.

State Registrar

31. Date filed (Month, Day, Year) MAR 2



ORIGINAL

			For State Registrar		State	e of Mai	ryland / De <i>C</i>	oartme e <i>rtifica</i>				ental Hy	giene Reg. No.	And the same of th	10772												
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Clork									2. Date of De		2000	3. Time of Death												
Nag.	Exami		4a. Facility Name (If n 216 N. Le	e Stree	et			Cu	mber				Alle	ounty of Death													
	Funeral Director		5. Social Security Nun 214-34-17 Usual Residence of D	757	6. Sex	c	(In yrs. last birthda 70 Yrs.	y) If Und Month	er 1 Year S Days	If Under Hours	Min.	8. Date of Bir Month, Da Dec 2	, 1935	9. Birth	place (State or Foreig												
	Maryland I-f ehow	tor		10b. County Alleg	any		Oc. City, Town or Cum	Location Iberla	nd						10d. Inside City Limits 1 ☐ Yes 2 ☐ No												
	h with the 23a or 28s	Funeral Director	10e. Street and Numb 216 N. Le		et	10f. Zip Code 215				21502	2		_	of What Cou	intry?												
9036	72 hours after death with the Maryland natural', or tems 23a or 28a-f show after Examinet must be putilled at	þ	11. Marital Status 1 □ Never Married 3 □ Wayvidowed 4	_	Armed 1 TY If Yes	Decedent Evd Forces? es 2 No Give X or Dates:		8. Was Dec If Yes, sp 1 ☐ Yes		lispanic Or an, Mexica Specify:		cify Yes or No lican, etc.)		Race - Ameri Black, White Decify: White	, etc.												
21215-0036	within 8ne. Ithen *	Completed	(Specify Elementary/Second	lary (0-12)	grade complet	<i>ted)</i> ge (1-4or 5+)	(Gir	edent's Us re kind of w DO NOT make	rork done use retired	durina mos	st of workin	g	16b. Kind	of Business/Ir	ndustry												
Maryland	vould be filed i Mental Hygi narked other natic event, it	To Be (17. Father's Name (Fig.		. *					Edr	na S	(First, Middle, Sciese															
	t and 2 sho Heelth and em 27 is m		19a. Informant's Nam Raymond	Devor		son	HC	52 B	ox 13	and Numbe 76		Augu	er, City or To sta	own, State, Zij	WV 26704												
Baltimore,	Pages lent of nt: if it ry or o		20a. Method of Dispos 1 XBurial 2 0 4 Donation 5	Cremation : ☐ Other (Spe	ecify)	rom State	20b. Place of Dis cemetery, co Sunset Me	ematory or	other place	(8)	Da 4 ,	/3/2006		ion - City or T berlanc													
Bal	permit. Depertming imports any inju		21. Signature of Fune	201	An	M	VI	10	8 Vira	inia Av	enue;	ne, P.A. Cumber	land, M	D 21502)												
100	Physician /Medical Examiner		23a. Part. Enter the shock, or heart f Immediate Cause (Fir disease or condition resulting in death)	allure. List o	nly one cause o	on each line.	e death. Do not e		de of dyin	g, such as		respiratory a		al	Approximate Interval Between Onset and Death												
68760, 🗸 📕	icate be executed physicien and the burial-transit	ıysıclan/Medicai Examiner	edicai	edicai	edicai	edicai Exa	Exa	edicai Exa	edicai Exa	edicai Exa	edicai Exa	edicai Exa	edicai Exa	Exa	Sequentially list condi if any, leading to immo cause. Enter Underly, Cause (Disease or inji that initiated events resulting in death) Las		c		conseq ence of):	PU ZVE	7	01512	112			G /3	ory 7 year
P.O. Box 68	the death certifi y the attending ched for use as													IF FEMALE: 23b. Was decedent pr in the past 12 mc 1 Yes N 9 Unknown	onths?	1□Liv 4□Pr	outcome of ve birth 2 [regnant at tin	Fetal death 3	□Ectopic p □ Other (s					23d.	Date of delive	ery Day Year	
	law requires that as been signed by 2 should be deta	þ	Part II. Other significa		s contributing t	o death but r	not resulting in the						obacco use d		he cause of death?												
Division of Vital Records,	The ete h	Complete	Completed	DIA	BETE	S 1	MELLI	TUS					24a. Was autop perfor 1 Yes	an 2-	4b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of											
f Vit	S . S .	To Be	25. Was case referred examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1	☐ Inpatient	2 ER/Outpatio	ent 3⊡ D	OA Othe	ar-		Check only o	1	Other (Specif	(v)												
sion o	To the Hospital or Attending Physician: whithin 24 hours after death as the feath To the Funeral Director. After this certific completely filled in by the funeral director,	Certification:	2 🗹 Accident	5 ☐ Pending investiga	tion (A	ate of Injury Month, Day Y	ear) 28b. Time Injury	of M	28c. Injury Work		28	d. Describe h															
D X:	urs after d rral Direct		4 Homicide	6 Could no determin	ed 286. Pl	vilding, etc. (City or Tow	m, State)		al Route Number,												
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1's (Check only 2 one)	Certifying Medical Ex	taminer: On th	the best of n e basis of ex nanner stated	ny knowledge, dea amination and/or i d.	th occurred nvestigation	at the tim	ie, date and pinion, deal	d place, an th occurred	d due to the d at the time, d	cause(s) and date and pla	manner as s ce, and due to	tated. o the cause(s)												
)	To the To the comp	×	29b. Signature and title	1	Tellm			- 1	c. License					gned (Month,	Day, Year) 2006												
	8		30. Name and address Hariit Sic 31. Date filed (Month,		_	ause of deat		. ,	p Wa	lsh R	oad C	umber	land M	1D 2150	02												
DH	Sta Registr MH 17 Rev 1/20	ar	31. Date filed (Month,	P 6 6	2006	Registrar's	Signature																				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registres Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2004 0826 Ollie \mathbf{E} Cannon Masch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wican . co REGIONAL MEDICAL SAUSBURY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | May 8 1918 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2 🕶 F 221-10-3517 87 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other then "natural", or iteme 23a or 28a-f ehov traumatic event, tre Madical Examinar must be notified at 1 Nes 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 570 Village Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3altimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic None 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Dashiell Augustus Long 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27408 Edgewood Cir.Salisbury, Md. 21801 Oscar Cottman (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Injury or permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 3-27-06 Salisbury, Md. Green Acres 21. Signature of Funeral Service Licensee ²S Name and Address of Facility
Stewart Funeral Home
821 West Rd.Salisbury,Md.21801 Gladys B. Stewart 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION
Due to (or as a consequence of): Physician MINATES /Medical Examiner CONGESTIVE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit ATRIAL Division of Vital Records, P.O. Box 68760, TENSION Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Minknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of centie H48241 unk 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DO STORIVERSIDE DR #6 SAUSBURY, MAKAS. F. DANIEL 31. Date filed (Month, Day, Year) MAR 23 32. Begistrar's Signature State 2006 Sparke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De State of Maryland / De State Registrar 3-31-06 Amend#17.PerInfint.PGC cr	epartment of Health and N Certificate of Death		ene 0 0 6	10774
P	خ _{ارا} یة Dhyciai	22	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		EDWARD LUMPKIN DAVIS, Sr.		March 19		11:45 a ^M
	Examir	ıer	4a. Facifity Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Casey House	Rockville		Montgomer	У
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho 1 ☑ M 2 ☐ F 92 Yr.	Months Days Hours Min	8. Date of Birth (Month, Day, Y	ear) Cou	place (State or Foreign ntry)
	Director		216-14-4122 Yr. Usual Residence of Decedent	j.	May 10,		yland
	land ow		10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
	Mary Figh	ģ	Maryland Montgomery Gaither	shura			1 X Yes 2 ☐ No
	r 28s	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	23a o	a D	217 Booth Street, Apt. 128A	20878		J.S.A.	,
	dea	Funeral		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ameri	
9	or it	F	1 Never Married 2 Marned 1 M Yes 2 No	1 ☐ Yes 2 ☑ No Specify:	Hican, etc.)	Black, White,	etc.
8	ural',	d by	3 Wildowed 4 Divorced Year or Dates: WWII	TO 100 ZESTRO Specify.		Specify: Wh:	ite
5	within 72 hours after death with the Maryland ane. then 'natural', or iteme 23a or 28a-f ehow fa Masileal Este', irrer must be rotified at	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation live kind of work done during most of work	ing	b. Kind of Business/In	dustry
12	withly she withly then	Ę	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired) eSman		ontgomery	Truck
9	Hygid Hygid ther	e Co	1.7. Father's Name (First, Middle, Last)		W e (First, Middle, Mai	ard	/ Tires
an	o be c	To B	Louis Rouis E. Davis			,	
2	Should Mand	F		ailing Address (Street and Number or Rura	Virgini	a Lumpkin	Code
Š	ulth ar 27 is r trau		F14 .1 .1 P P P				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. any injury or other traumatic event, the Maralcal Exterior must be notified at once.	100	20a. Method of Disposition 20b. Place of Disposition	7 Booth Street, Apt sposition (Name of promatory or other place)	• 120A . G	C. Location - City or To	MD 20878 own, State
Ë	Page Bent c Int: If ry or		Donal /2 Michallon 3 Diffellioval Itolii State	itan Crematory 3/22.	/2006 A	lexandria,	Water and and a
alti	mit.		21. Signature of Funeral Salvice Licensee	22. Name and Address of Facility Gas	sch's Fun	eral Home.	P A
m	88 2 8	. 10	Ren L Technel	4739 Baltimore Ave	, Hyatts	ville, MD	20781
п			23a. Fart1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final dispase or condition a Cerebrovascular	Accident			Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	Accident			
	Examiner		Sequentially list conditions, b				
	e sit	Examiner	flany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
	and I-tran	хап	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	aiE	200 to (of all a contacqualities of).				
687	ficate phys s the	edicai	d				0
X	eath certific attending p	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d Date of deliver	
m	death e atte d for	cla	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	Day Year
P.O. Box	by the detached	hys	9 ☐ Unknown 9 ☐ Unknown				
'n.	res tha igned be de	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	co use contribute to th	ne cause of death?
Records,	w require been sli should t				1 🗆 Yes	2X No 3 ☐ Prob	ably 4 □Unknown
ပို့	as be	pie			24a. Was an	24b. Were auto	psy findings available inpletion of cause of
		Completed			autopsy performed 1 Yes 2	l? death?	2 No
Vital	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	26. Place of Death			20110
	this aldi	္	1 ☐ Yes 2 💢 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa		ne 5 🗆 Residence	6 Other (Specify	/ Hospice
ב	Attending Physician: r death. ector: After this certific by the funeral director.	i o	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	y Work?	28d. Describe how in	njury occurred	
Sic	death death ctor: / the f	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 ☐ Yes 2 ☐ No			
	_ 0	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specity)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura. tate)	l Route Number,
	ig 8 9 m ≡		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, de	19th Occurred at the time, date and place a	and due to the source	-(-)	
	To the Hospital o within 24 hours eft To the Funeral Di completely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	and at the time, date	and place, and due to	the cause(s)
	To the I within 2 To the I complet	Ž	29b. Signature and tive of certifier	29c. License number	29d.	Date signed (Month, L	Day, Year)
			1 Jagon mo	D35635	Man	rch 20, 20	06
1	15)		30. Name and address of person who completed cause of death (ftem 23a) (Type	e, Print)			
	0		Joseph Kaplan, MD 6001 Muncaster 1	Mill, Rockville, Man	yland 208	355	
	Stat Registra		31. Date filed (Month, Day, Year) MAR 2 3 2006	de la companya dela companya dela companya dela companya de la companya dela c			
			HILLIAN SO FORD				

3H-10 State

RJ

Registrar DHMH 17 Rev 1/2001 31. Date filed (Month) Day_Year) 32. Registrar's Signature 111 Penn Street

Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 06 /Medical Vernon Charles Downes 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Denton
If Under 1 Year | If Under 24 Hrs. <u>Hospice</u> Caroline Caroline 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 24, 1950 Birthplace (State or Foreign Country) **Funeral** 1**ℤ**M 2□F Days Hours Yrs. Director 217-54-5543 55 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Even treum be notified at 1 Yes 2 ☐ No Maryland Caroline Denton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 200N. 4th Street 21629 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 9 Equipement Operator Town of Denton 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Rufus Downes Dorothy Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 N. Street, Denton, Maryland 21629 Downes / Sister Rosetta 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State permit. Page Department o Importent: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 04-01-2006 Spring Grove Cem. Denton, Maryland 22 Name and Address of Facility
Bennie Smith Funeral Home <u>426 Dover Street, Easton, Maryland 21601</u> Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician -4NG ANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 Other (specify) Records, P.O. detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No Division of Vital 2 No 1 Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 ther (Specify) HOSPILE 1 ☐ Yes 2 No ۵ in by the tuneral dir 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a To the Funerel (29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of cert 29d. Date signed (Month, Day, Year, 10053815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARKET STREET DENTUN MD 912 MULIMOOD 31. Date filed (Month, Day, Year) State MAR 2 7 2006 Registrar

Warren Denes 06-01881 dl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 1.			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		ent of H				giene Reg. No.	006	10777
			1. Decedent's Name (First, Middle, La	st)	· · · · · · · · · · · · · · · · · · ·					2. Date of Dea Month		Ye	3. Time of Death
	Physici /Medio		Warren Keith	Denes						March	16,	2006	6:02 P M
	Examir	ner	4a. Facility Name (If not institution, giv	_		4b. C	ty, Town, o	r Location of	of Death		4c.	County of E	Death
			21 Coachmans Roa 5. Social Security Number 6. S				verna der 1 Year	Park If Under	24 Hrs	0.0 (17:4)		ne Arı	
	Funeral Director		-	Max 7. Ag Max 2 F	e (In yrs. last birthda 32 Yrs.	Mont		Hours	Min.	8. Date of Birtl (Month, Day Apr. 28	, Year)	973	Birthplace (State or Foreign Country) MD
			Usual Residence of Decedent							Apr. 28	J ₁ 1.	973	לוניו
	ylan, how		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
	a Ma	cto	MD Anne A	rundel			Ar	nold					1 ☐ Yes 2 No
	or 24	Dire	10e. Street and Number	- 1		10f.	Zip Code	04040			10g. Citi:	zen of Wha	•
	s 23a	ra	811 Mago Vista		F :- 110 140			21012			1.		USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other treumatic event, the Madical Exacultar round be nutilised at Once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			cedent of H pecify Cuba 2 2 No	Specify:		ecify Yes or No- Rican, etc.)	1		American Indian, Vhile, etc. White
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a. Dec	edent's U	sual Occup	ation			16b. Kir	nd of Busini	ess/Industry
215	hin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5	life	DO NO	work done of use retired	during mos ()	t of worki	ng			
2	ygien /gien f. me	S	12			eliv	ery Pe	erson				Domin	oes Pizza
pu	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r freumatic event, the Med	Be .	17. Father's Name (First, Middle, Last							(First, Middle,		Surname)	
χ	ould Men Parke	ျ	Roy Bennett Den							ine Nuz			
Maryland	12 sh h and 7 is n Ireun		19a. Informant's Name/Relationship (_				al Route Numbe			_
	1 and Healt em 2	loo.	Jacqueline A. No	uzzo/Motne	20b. Place of Dis	position (vame of			Arnold,		2101 cation - City	or Town, State
ခဲ့	ages nt of t: # tt		1 Burial 2 ☐ Cremation 3 ☐		cemetery, cr	ematory`	r other plac		Mar.	20,			is, MD
Baltimore,	ortani Injury		4 □ Donation 5 □ Other (Specifical Service Licer					-		006			
Ba	Depermine Depermine Important Irriginal Irrigi		Homas	Hlen	7	Barr	anco	& Son	s, P	.A. Seve wy, Seve	erna erna	Park	Funeral Home MD 21146
			23a. Part1. Enler the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not e							- 0-11	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	T		1110	hot	112	DUI	ud			Onset and Death
4	/Medical		resulting in death)	Due to (or as	a consequence of		Va C		0 000				
	Examiner		Sequentially list conditions,	b									
	be sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence oi):								
_	death certificate be executed e attending physicien and of for use as the burral-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as	a consequence of):								
8760,	sicien buris	dical E		· .									
687	ficate p phy: as the	edic		_ d,			_						
Box	leath certific attending p	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, oulcome	of pregnancy	Oc.					2	3d. Date of	delivery
	deatl	lcia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		☐ Other	pregnancy (specify)					Month	Day Year
P.O.	that the de led by the a detached t	Physician/Me	9 ☐ Unknown										
Records,	w requires that the been signed by th should be detache	þ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	underlyin	g cause give	en in Part I.		23e. Did to		1	e to the cause of death? Probably 4 □Unknown
မင	2 s b	Completed								24a. Was a autop		24b. Were	a autopsy findings available to completion of cause of
<u>۳</u>	Ta este	Con								perfor	med? 2 □ No	deatl	n?
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	11			100		of Death	(Check only or	ne)	-	
of	S 5	ဥ	1X Yes 2 No	Hospital: 1 ☐ Inpalie				4 L INU		ne 5 ☐ Resid			Specify) scene
n C	sting f	lon	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day FOUND 31)	Year) jojury	or PM	28c. Injun Work		1	28d. Describe h Dec <i>easec</i>	() 0.0	cocured	relf
isio	Attending ir death. ector: Aftei by the fune	lcat	2 Accident investigation 3 Suicide 6 □ Could not b		ury - At home, farm,	<u> </u>		Yes 2 1		28f Location (S	treet and	1 Number o	Rural Route Number
Division of Vital	after after Direction by	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	sileet, lac	ory, onice				P- 1	21 000	Rural Route Number Ro
_	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Pt	ysician: To the best of	of my knowledge, dea	ath occurr	ed at the time	ne, date an	d place, a	and due to the c	1011 ause(s)	and manne	71146 AA. Co
	n 24 t	edical	(Check only 2 Medical Exar	niner: On the basis of and manner sta	examination and/or	investigat	on, in my o	oinion, dea	ih occurre	ed at the time, d	late and	place, and	due to the cause(s)
	To the within To the comp	Me	29b. Signature and the of certifier	. ////			29c. License	number		2	9d. Date	signed (M	onth, Day, Year)
			XXXX	WIN			OCME	7,		N	íarch	17,	2006
				completed cause of de	eath (Item 23a) (Type	e, Print)							
				t N	1.0	113	Penr	Stre	eet,	Baltimo	re,	Mary1	and 21201
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	all E							

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 6	178
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Zie Year 22 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	e of Death 320 M
	Funeral Director	<u> </u>	Washington County Hospital Hagerstown Washington 5. Social Security Number 6. Sex 1/2 M 2 F 91 Yrs. Hagerstown Washington Washington Hunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. (Month, Day, Year) West Vir	te or Foreign ginia
	the Maryland r 28a-f show natified at	Director		e City Limits Yes 2 No
036	d within 72 hours after death with the Maryland Jiene. r than "neturel", or items 23a or 28s-f show The Madical Examinar must be maiffied at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. A. 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indiar Black, White, etc. 1 Yes 2 No Specify: Specify: White	ı,
121215-0036	d within giene. ir then	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales 16a. Decedent's Usual Occupation (Give kind of working life. DO NOT use retired) Manufacturing	
Maryland	d 2 should be file th and Mental Hyg 7 is marked othe traumatic avent,	To Be	17. Father's Name (First, Middle, Last) Floyd Granville Fawver 19a. Informant's Name/Relationship (Type, Print) 18. Mother's Name (First, Middle, Maiden Sumame) Beatrice Lee Kline 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Baltimore, M	es 1 an of Heal f Item 2 ir other		Marianne H. Rennie / Step-daughter 2539 Slateshire Dr Dublin Ohio 43016 20a. Method of Disposition 1	
Baltin	permit. Pag Department: Important: 1 any injury o		21. Signified Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown Maryland	21742
8760,	Physician / Medical physician and physician and physician and the phuai-transit	Icai Examiner		Batween nd Death
O. Box 6	he death certific the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1	Year
Δ.	w requires that the bound by should be detact	þ	Part #. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of the cau	
Vital Records,		e Completed	Perchasical 24a. Was an autopsy finding autopsy performed? 1 Yes 2 PNo 25. Was calle referred to medical 26. Place of Death. Check only one)	gs available of cause of
Division of Vi	ling Phys n. After this funeral dir	To B	examiner? 1	
Divis	To the Hospital or Attence within 24 hours after death to the Funeral Director: completely filled in by the	ai Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No. City or Town, State)	umber,
	To the Hospital or A within 24 hours after To the Funeral Directon Distribution of the Funeral Directon Distribution Distribution Distribution Distribution Distribution Distribution Distribution Distribution Distribution	Medica	(Chack only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	
)	F 3 F 8		Fuere @ Decements HOO6117 MARCH 27 2	(006
	H-5	to	30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 251 E. Antretown 57 Flam C(SCE A Deucell Do Hogo Stave MD 21743 31. Date (iled (Month, Day, Year), 32. Registrar's Signature	
	Registr		MRK 28 2000 10 10 10 10 10 10 10 10 10 10 10 10	

1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 22 2006 5:45PM MARCH 22 2006 200				For State Registrar	State	of Marylar		artment rtificate				lental Hy	giene Reg. No.	006		0779
4. Facility Attacher if not received by a faced and numbers of the control plane. **TILIZAM PLLI, HRACTIFE CARP **TILIZAM						GERALD						Month	eath Day	2	006	
Second Second Number Control C								4b. City, T	Town, or	Location	of Death					3. 13111
The control of the co																
10. Same 10. Convey BAT TALBOT TALBOT	ı			212-07-8511								8. Date of Bir (Month, Da MARCH	th ay, Year) 9 191	4		
The property of the property o		land			у	10c. Ci	ity, Town or Lo	cation			-				10	Od. Inside City Limits
The property of the property o		Mary a-f sh	tor	MD TAI	BOT		EAST	ON								XX Yes 2 ☐ No
The property of the property o		ith the)ire	10e. Street and Number				10f. Zip (Code				10g. Citiz	en of Wh	at Count	try?
The property of the property o		s 23e	rai													
The property of the property o	36	ırs after d∉ bi', or item Xa⊤iner r		1 Never Married 2 Ma	rried Armed F	orces? 24 No ive	ĺ					ecity Yes or No Rican, etc.)	1	Black,	White, e	etc.
The property of the property o	2	72 hol	ted	15. Decede	nt's Education)	16a. Dece	dent's Usual	l Occupa	ation	t of work	ina	16b. Kin	d of Busi	ness/Ind	ustry
The property of the property o	2	vithin ne. han "r	mpie	Elementary/Secondary (0-12)	College (life.	DO NOT use	e retired)	l or work	ing .	CAT	EC M	ra wa c	PEMENT.
Pity slote: Pity slote:		Hygie Hygie ther t					K	ETAIL	SAL		er's Nami	a (First, Middle				-EMEN I
Pity slote: Pity slote:	<u>Ilan</u>	uld be Mental rked o											, 17/2/00// 0	, amamo,		
Pity slote: Pity slote:	lar	2 sho and h is ma						-								Code)
Pity slote: Pity slote:		1 and Health em 27 ther t	i į		TZGERALD/					SS CI						um Stato
Pity slote: Pity slote:	nor	ages ont of l it: If its y or o		1 Burial 2 □ Cremation		State	cemetery, crer	natory or ott	her place		_				· .	
Pity slote: Pity slote:	뵱	ortme crten injury			<u> </u>	31				4 #8 111			_			
Another Pearl Bullium. List only one eause on each line. Interval Between Information Course (Pinal resulting in death) State Shock or heart failure. List only one eause on each line. Interval Between Information Course (Pinal resulting in death) State Shock or heart failure. List only one eause on each line. Interval Between Information Course (Pinal resulting in death) Shock or heart failure. List only one eause on each line. Interval Between Information Course (Pinal resulting in death) Shock or heart failure. List only one eause on each line. Interval Between Information Course (Pinal resulting in death) Interval Between Information Course (Pinal resulting in death) Interval Between Information Course (Pinal Resulting in Information Course) Interval Between Information Course (Pinal Resulting in Information Course) Interval Between Information Course (Pinal Resulting in Information Course) Interval Between Information Course (Pinal Resulting in Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval Between Information Course (Pinal Resulting Information Course) Interval B	ä	Per Dep any) TIGHN	R. MER	CERS		OO S.	HAR	ELFEI RISON	A ST	, EAST	NAM E	D 21	601	IOME PA
Temporary Temp		Physician		shock, or heart failure. Lis Immediate Cause (Final	r complications that t only one cause on	caused the dea each line.			_	4.20		or respiratory a	rrest,			Interval Between Onset and Death
Temporary Temp				resulting in death)	Due to	r as a consec	quence of):	16	0							
State St			-	Sequentially list conditions,		LUN ON	1°C	Hypi	7.5	2-54	an				1	ogers'
Second S		uted d ansit	min	cause. Enter Underlying Cause (Disease or injury	\	(,	/								
FEMALE: 23d. Date of delivery 23d. Date of deliv	o,	e exectan an an arial-tr	Еха		Due to	(or as a consec	quence of):									
FEMALE: 23d. Date of delivery 23d. Date of deliv	876	cate be chysici the bu	dicai		d											
Cervical Myelandry 24a. Was an autopsy performed? 1 yes 2 No 25. Was case referred to medical evariance? 1 yes 2 No 25. Was case referred to medical evariance? 1 yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Work 20 No 28b. Describe how injury occurred 28c. Injury at Work? 28c. Injury at Work? 3 State 28c. Cartifier 28c.	9	certific oding p	/Me		23c. If yes, ou	itcome of pregn	ancy						2.	3d Date	of deliver	
Cervical Myelandry 24a. Was an autopsy performed? 1 yes 2 No 25. Was case referred to medical evariance? 1 yes 2 No 25. Was case referred to medical evariance? 1 yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Work 20 No 28b. Describe how injury occurred 28c. Injury at Work? 28c. Injury at Work? 3 State 28c. Cartifier 28c.	ă	death e atter d for L	iciar	in the past 12 months?	1☐Live 4☐Preg	birth 2 ☐ Feta nant at time of c	aldeath 3□						2.			•
Cervical Myelandry 24a. Was an autopsy performed? 1 yes 2 No 25. Was case referred to medical evariance? 1 yes 2 No 25. Was case referred to medical evariance? 1 yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Work 20 No 28b. Describe how injury occurred 28c. Injury at Work? 28c. Injury at Work? 3 State 28c. Cartifier 28c.	0	at the by the	hys	9 Unknown												
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1		quires the signed and be de		Part II. Other significant condit	/_ /	leath but not res	sulting in the ur	nderlying ca	use give	en in Part I.						
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1	900	law re as bee 2 sho	piet	Cervica	a myelo	grafty						24a. Was	an	24b. We	ere autop	sy findings available
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	ž	The zate has page	Com	Hy poth	wordisz	, -						perfo	ormed?	dea	ath?	
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	Vita	icien: sertific ector,	Be	examiner?					011							
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	ot	Physic rthis cral dir			1 1 1			-	1	4 140	_					
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	on	nding th. : After	tion	1 Natural 5 ☐ Pendi	ng (Mor	nth, Day Year)			Work	?		20d. Describe	now injury	00001180		
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	N N	er dea	tifica	3 ☐ Suicide 6 ☐ Could	nined 286. Place	e of Injury - At h	ome, farm, str	eet, factory,	office			28f. Location (Street and	Number	or Aural	Route Number,
30. Name and address of person who completed gause of death (Item 23a) (Type, Print) LUSSELL A Schuling & 555 Groward & Easton and 21601 State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	ā	itel or irs aftr rel Div led in														
30. Name and address of person who completed gause of death (Item 23a) (Type, Print) LUSSELL A Schuling & 555 Groward & Easton and 21601 State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature		ne Hosp 1 24 hou se Fune letely fil	dicai	(Check only 2 Medica	Examiner: On the b	pasis of examina	owledge, death ation and/or inv	n occurred a vestigation, i	t the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	ind mann place, and	er as sta d due to	ited. the cause(s)
30. Name and address of person who completed gause of death (Item 23a) (Type, Print) LUSSELL A Schilling to 555 Cymrodd DV Easton and 2661 State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature		To th withir To th comp	¥	29b. Signature and title of certific	er 1			29c.	License	number)		29d. Date	signed (Month, D	Pay, Year)
State 31. Date filed (Month, Day, Year) 32. Egistrar's Signature	•			Male	40V 80			H	(4)	481	/		03	23	120	06
State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	1	-li-			who completed cause which has a				C E	V E	asto	n end	211	501		
						ogistrar's Signa		Soul !)							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylar				lealth an D <i>eath</i>	nd Me		ene	16	107	80
	Physici	ian	Decedent's Name (First, Middle, La							Date of Death Month	Day 17	Year	3. Time of	
	/Medio	cal	George Melv: 4a. Facility Name (If not institution, giv			4h Cih	Town as	Leasting of 5		March		2006	9:57	A M
	Examir	ner	10107 Thrift	,		4b. City	, rown, or	Clinte				nty of Death	George	٥, ٩
	Funeral			Sex 7. Age (In yrs.	last birthday)		r 1 Year	If Under 24		8. Date of Birth		9. Birthp	lace (State o	
1-4	Director		578-46-9129 Usual Residence of Decedent	1₫M 2□F 6	8 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, May 3,	1937	Was	h., Do	3
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Iteme 23e or 28e-1 show any figury or other traumatic event, I'm Muclical Examinational Le notified at once.	tor	10a. State 10b. County Maryland Prince (ty, Town or Lo	ocation	C.	linton				1	0d. Inside Ci 1. ∑Yes	ity Limits 2 🗆 No
	or 28s	Funeral Director	10e. Street and Number	8		10f. Zi	p Code			10	g. Citizen o	of What Coun	try?	
	ath wi	rai	10107 Thrift	Road				20735			U	nited	States	S
	iteme	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dece If Yes, spe	dent of Hi	ispanic Origin n, Mexican, P	? (Spec Puerto R	ify Yes or No- ican, etc.)		ace - Americ lack, White,		
36	rs aft	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:	ĺ	1 🗆 Yes	2 X No	Specity:			Spec	city: B1	ack	
21215-0036	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usi	al Occupa	ation		10	6b. Kind of	Business/Inc	lustry	-
215	hin 7.	pie	(Specify only highest gra	ade completed) College (1-4or 5+)	(Give	kind of w DO NOT i	ork done d use retired,	luring most of)	f working	9			,	
2	ed wit	Completed	12th			Bui	lding	g Engi	neer		G	overnm	ent	
nd	d oth	Be	17. Father's Name (First, Middle, Last,					18. Mother's	Name ((First, Middle, Ma		,		
Z	ould Mer narke	T ₀	George E.							Edna Ma				
Maryland	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (-						Route Number, (m, State, Zip	Code)	
	Heal Heal tem 2		Jean M. Greene 20a. Method of Disposition	20b. F	Place of Dispo	sition (Na	me of		, Cl Da	inton, l		0 735 n - City or To	wn, State	
altimore,	ages ent of ht: if i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Inemoval nom State	cemetery, crer nco1n N				1241			itland		
<u>=</u>	mit. F sartm sortar Inju		21. Signature of Funeral Service Lice	£1				s of Facility		tewart 1				
m	Depa Impo		John T. St	evoge TIL	1	4	001 I	Benning	g Rd	., N.E.	Wash	., DC	20019	
10h	Physician /Medical		23a. Part1 Enter the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Carcinom	na of t				rdiac or	respiratory arres	it,		Approximate Interval Bette Onset and I Month	ween Death
	Examiner			Due to (or as a conseq	juence of):									
		er	Sequentially list conditions, if any, leading to introductions cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	ue ice of).									
	ficate be executed physicien and is the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.										
ó	en an	Exa	resulting in death) Last	Due to (or as a conseq	uence of):									
8760,	ate be nysici he bu	icai		_ d.										
9	ing pl	Med	IF FEMALE:			-								
P.O. Box	The law requires that the death certificate be executed to has been signed by the attending physicien and age 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic p Other (s	regnancy oecify)				1	Date of delive Month		Year
<u> </u>	that ned by deta		Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did toba	cco use co	ntribute to th	e cause of d	leath?
rds	quires n sign	ed by								1 ☐ Yes	2 🔀 No	3 🗌 Proba	ably 4 🗆 L	Inknown
000	aw require s been sig	Completed								24a. Was an	24b	. Were autop	sv findings a	available
ž	The lav	Шо								autopsy performe	1	prior to con death?	npletion of ca 2 □ No	ause of
<u> </u>	hysician: The la his certificate has I director, page 2	Be C	25. Was case referred to medical					26. Place of	Death (Check only one)	J NO	1 1 1 1 1 1 1 1	2 140	
<u>></u>	hysic this ce al dire	Tof	examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 🗆 D	Othe	r: 4 ☐ Nursir	ng Home	e 5 X Residen	ce 6 🗆 O	ther (Specify)	
Ē	Jing P. After t	on:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	at ?		d. Describe how				
SIO	Attending Physician: r death. sctor: After this certifica by the funeral director.	cati	2 Accident investigation 3 Suicide 6 Could not be	9		М		es 2□No						
Division of Vital Records,	Hospitel or Atten 24 hours after deatl Funeral Director: stely filled in by the	Certification:	4 Homicide determined	building, etc. (Specif	y) 					f. Location (Stre City or Town,	State)			ber,
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in:	occurred estigation	at the time	e, date and p inion, death o	occurred	d due to the cau I at the time, date	se(s) and n and place	manner as sta e, and due to	ated. the cause(s))
	To the within 2 To the complet	Σ	29b. Signature and title of certains			29	c. License	number		290	l. Date sign	ed (Month, E	lay, Year)	
	0							D19431			Ma	rch 21	, 200	6
R	- (5)	<u> </u>	30. Name and address of parson who Frank M. Rya			,	n Rd.	, Ste.	103	B, Ft. W	ashin	igton,	MD 20	744
	Sta Registr		31. Date filed (Month, Day, Year) MAD 9 3 2006	2. Registrar's Signa	iture.	R.								

			1 - For State of Many		artment of H			giene) () 6 leg. No.	10781
14°	Physici /Medic		1. Decedent's Name (First, Middle, Last) William Reyer GAI	JTHIER			2. Date of Dea Month	Day Yea	
*	Examin		4a. Facility Name (If not institution, give street and number) Washington County Hospital		4b. City, Town, or Hagerst	own		4c. County of D Washing	eath ton
	Funeral Director		5. Social Security Number 380-26-5448 Usual Residence of Decedent	76 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		1930 M:	Birthplace (State or Foreign Country) Lchigan
	r 28a-f ehow	Irector	The state of the s	C. City, Town or Lo Hagersto				log. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2√2 No Country?
036	ould be filed within 72 hours after death with the Maryland Mennal Hygiene. riked other than "natural", or terna 23a or 28a-f ehow nite event. The Medical Examinar must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 11. Marital Status 12. Was Decedent Eve Armed Forces? 12. Yes 2 No If Yes, Give Year or Dates:	194/-	217 Was Decedent of H If Yes, specify Cuba 1 □ Yes 2X No	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	U.S. 14. Race - A Black, W Specify: W	merican Indian, hite, etc.
21215-0036	id within 72 h giene. er then "netu	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0-12 1	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of v ()	vorking	16b. Kind of Busine	ŕ
yland	should be filed ind Mental Hygi s marked other umatic event, I	To Be (17. Father's Name (First, Middle, Last) Thomas Joseph Gauth				lame (First, Middle, Bernic	e Reyer	
e, Mar	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) Mrs. Patricia J. Gauthier-wif 20a. Method of Disposition		Englewoo			r, City or Town, State wn, Maryl 20c. Location - City	and 21740
Baltimore, Maryland 21	permit. Pages Department of I Important: If It eny injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Hagerston	matory or other place wn Cremat 2. Name and Address	ory Ma 2 ss of Facility	rch 27, 006 Minnic	Hagerstow h Funeral	n, Maryland Home
	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	death. Do not en					Approximate Interval Between Onset and Death
8/60,	Medical Examiner bhysician and bhrial-transit site burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition of the cond	onsequence of): Bycuc (onsequence of):	retent witis		ې څرنځ		
O. Box 6	law requires that the death certific as been signed by the attending p 2 should be detached for use as:	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ords, P.	w requires that been signed b should be deta	þ	Part If. Other significant conditions contributing to death but no Liye Ae in Sc Cur				1 □ Y	es 2□No 3ᡚ	to the cause of death?
Vital Records,	The ate h page	Completed	ATrial Fibrilletion u Response	ATM 12	epid Ve	on Trice	- autop: perfor	svprior	autopsy findings available to completion of cause of ? es 2 No
Division of Vit	ding Phys h. Atter this funeral di	ation: To Be	25. Was case referred to medical examiner? 1	2 ER/Outpatier 28b. Time o	f 28c. Injury Work	er: 4 Nursing		ence 6 □Other (S ow injury occurred	pecify)
DIX		Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (5	Specify)			City or Tow	n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1.2 Certifying Physician: To the best of m (2 □ Medical Exeminer: On the basis of example and manner stated and manner stated (29b. Signature and title of certifier	amination and/or in	vestigation, in my op	oinion, death oc	curred at the time, o	ause(s) and manner late and place, and o 29d. Date signed (Mo	lue to the cause(s)
	F 3 5 8		> Freed Q Deced	70	400			Ŧ .	24, 2006
St	17+1	, i *	30. Name and address of person who completed cause of death 251	Signature	ogess well	icun,	MD	21740	
100	Sta Registr		MAR 2 7 2006 Sacus	B. 19	nede				

			1 - State Registrar	-	aryland / Der		Health and	Mental Hy	-) 6	10782
	Physic /Medi		Decedent's Name (First, Middle, La. ADDISON	CARROLI				2. Date of De Month March	Day 20,	2006	3. Time of Death 1:15 A M
36	Examir Funeral	ner	4a. Facility Name (If not institution, given Frederick Memor 5. Social Security Number 6. S	ial Hospit	_	Frede		rs. 8 Date of Ric	Fre	ty of Death deric	
	Director		719-16-3720 19	⊠ M 2□F	83 Yrs.	Months Days	s Hours M	in. (Month, Da Apr 24	1922	Love	ettsville VA
	be filed within 72 hours after death with the Maryland hal Hygiene. Id Hygiene. Id other than "natural", or items 23a or 28a-f show event, ite Madical Examinar must be notified at	rector	MD Freder 10e. Street and Number	ick	Knoxv				10g. Citizen of		1 XYes 2 ☐ No
	r death with	Funeral Director	256 Knoxville R	12. Was Decedent Armed Forces	Ever in U.S. 13		21758 Hispanic Origin?	(Specify Yes or No		SA ace - Americ ack, White,	
-0036	hours after tural, or It		1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ⊠Yes 2 ☐ If Yes, Give Year or Dates:	WWII	1 Yes 2 No	Specify:	,		ity: Whi	ite
Maryland 21215-0036	filed within 72 Hygiene. other than "na ent, it a Medic	Completed by	(Specify only highest gra Elementary/Secondary (0-12) 10	de completed) College (1-4or	(Gir	ve kind of work don DO NOT use retir Carma	e during most of v red)		Washin	gton	Terminal
ryland	should be fill and Mental Hy le marked oth aumatic even	To Be	17. Father's Name (First, Middle, Last, Carroll George 19a. Informant's Name/Relationship (Greene	19h Ma	ilina Addraga (Strong	Anna	Pauline Rural Route Numbe	Virts		2 Codol
Baltimore, Ma	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 le marke any injury or other traumatic Once.		Shirley Wilson, 20a. Method of Disposition 1 Buriai 2 Cremation 3 4 Opnation 5 Other (Specification 2). Since up of the analysis Licer	Daughter	20b. Place of Discemetery, co	-	nue, Brun	nswick, M Date 23/2006		6 - City or To	own, State
68760,	The law requires that the death certificate be executed by Way with the has been signed by the attending physician and consider the part of the part o	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as	d the death. Do not eine. a consequence of: a consequence of: a consequence of:		ring, such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
.O. Box	at the death certificat by the attending phy tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknows	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	Ectopic pregnan	су		1	ate of delive	ery Day Year
Records, P	aw requires that s been signed t s should be deta	Completed by Pl	Part II. Other significant conditions of the significant condition	Criti	out not resulting in the			24a. Was	Yes 2□No an 24b	3 ☐ Prob	he cause of death? pably 4 Minknown psy findings available
Vital Re		Be Comp	25. Was case referred to medical				26. Place of D	autor perfo 1 Tyes	20 No	death?	mpletion of cause of
of	ling Phys After this uneral dis	၉	examiner? 1 Yes 27. Manner of Feath Natural 5 Pending 2 Accident investigation		ry 28b. Time	of 28c. In		28d. Describe I			у)
Division	Hospital or Attend !4 hours after death Funeral Director: . tely filled in by the f	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, et	jury - At home, farm, : ic. <i>(Specify)</i>			City or Tox	vn, State)		al Route Number,
	To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exar 29b. Signature and title of certifier	ysician: To the best niner: On the basis of and manner st	of my knowledge, de of examination and/or ated.	investigation, in my	time, date and pla opinion, death oc	ce, and due to the courred at the time,	cause(s) and n date and place 29d. Date sign	, and due to	o the cause(s)
Ĺ	11A	9	3p-Name and address of person who	lesset	Seath (Item 232) (Tue	MD		o e Bransa			
イ	Sta	ato.	31. Date filed (Month, Day, Year)	dessed		10 94h	Avenu	e Bransa	irck my	160	716
	Registi			2006	_	Local ;					

se de

DHMH 16 Rev 6/95

State

Registrar

			_ For	State of Ma		/ Depa	artment of H	lealth and M		_	10701.
			1 - State Registrar			Cer	tificate of	Death		g. No.	10104
	sicia edic		1. Decedent's Name (First, Middle, La Cornelia Jaco						2. Date of Death March 2	1, Day 2006 Year	3. Time of Death 11:30 ам
,	eaic imin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	or Location of Death		4c. County of De	ath
		4	Talbot Hospice H	louse				Easton		Talb	
Fune Direc			5. Social Security Number 6. S 213-30-1765	Sex 7. Ag	e (In yrs. last 81	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 5,	9. Bi 1924 The	rthplace (State or Foreign Jountry) HOTTAND Nether Lands
pu ,			Usual Residence of Decedent 10a. State 10b. County		10c. City, T	oum or Lo	antian				10d. Inside City Limits
death with the Maryland	1	- L	,	act	Toc. City, 1	OWIT OF EG	Easton				1 Tyes 2 HMO
9 5 W		Directo		OL .					10	g. Citizen of What C	2000000
Mith 1			10e. Street and Number				10f. Zip Code	c04			
eath (erai	26199 Tunis Mills 11. Marital Status	12. Was Decedent	Ever in I.I.S.	13 \		601	acify Yas or No-	14. Race - Am	
fter d		Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐				lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, Wh	ite, etc.
urs al		2	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 2⊡No	Specify:		Specify: Wh	ite
be filed within 72 hours after death with the Marylan Ital Hygiene. All Hygiene Another than "natural", or items 23a or 28a-f show		Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	1	6a. Deced	ient's Usual Occup kind of work done	pation during most of work	ing	6b. Kind of Busines	s/Industry
within han han		ďω	Elementary/Secondary (0-12)	College (1-4or 5	5+)	IITO. L	no not use retired Bookkee:	•		Insura	70 0
filed v Hygie	1		17. Father's Name (First, Middle, Last	4			DOOKKEE	18. Mother's Name	e (First, Middle, M		iice
otal l	8	Be	Robert Christia							a Hoffman	
should be and Mental Me	1	ဍ	19a. Informant's Name/Relationship (I9h Mailin	na Address (Street			City or Town, State,	Zin Code)
5 P P P	2		Linda Heyman/Dau					ills Rd.,			
ore, Maryla s 1 and 2 should of Health and Men item 27 is marke			20a. Method of Disposition	igitter			sition (Name of natory or other place			20c. Location - City o	
permit. Pages Department of I	5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specific		I				22/2006	Cambrid e	MD
Dartillo Dermit. Pages Department of mportant: If it		ŀ	21/Signature of Funeral Service Lices		rizaoi						
Ded Per	S S	1	terslood Herr	ei- Kom	wee	0 1 2	10 Shore	Crematio	n Center	, MDO. 216	13 ¹⁴⁶⁴ ,
		1	299. Part1. Enter the lisease or com shock, or heert fall me. List only	plications that caused	the death.	o not ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
Dhysia			Immediate Cause (Final								Onset and Death
Physici /Medi	_		disease or condition resulting in death)	a. Due to (or as	a consequen	ce of):	01891	ndrom			6 mo
Examir	ner			Mes	ente	vic	avter	vy th	rombo	SIC	Como
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequen	ce of):		9			
rou, te be executed ysician and	2	Examiner	that initiated events	c							
a be exe		Ä.	resulting in death) Last	Due to (or as	a consequen	ce of):					
w requires that the death certificate be executed been signed by the attending physician and property to the physician and property to the physician to the phy	2	<u>ca</u>		d							
artifica ing pa	200	by Physician/Med	IF FEMALE:								
ath cer ttendir	200	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 ☐ Fetal de	ath 3□	Ectopic pregnancy	у		23d. Date of de Month	elivery Day Year
ie de the a	09	/slc	1 ☐ Yes 2 Z No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	1 5∟	Other (specify) _				•
hat it d by	Jelac	Ph	Part II. Other significant conditions	contributing to death b	ut not resultin	o in the u	nderlying cause gry	ven in Part I	23e. Did tob	acco use contribute	to the cause of death?
The law requires that the death certifica ite has been signed by the attending phonon of should be chanded for une of the	90	ğ	Atnal fibi			•	, , , , , , , , , , , , , , , , , , ,		1 □ Ye	s 2 X No 3 □ F	robably 4 Unknown
w requires been sign		ete	Dementia	101-0100	<u>'</u>				24a. Was ar		utopsy findings available
25 0 00	v I	Completed	_ Demen 119						autopsy perform	/ prior to	completion of cause of
r: Th	z.			·					1 ☐ Yes 2	ZNo 1 L Ye	s 2 No
ding Physician: The I h. After this certificate ha	138	Be	25. Was case referred to medical examiner?	Hospital:		(0	Oth	26. Place of Death		50000	HOSPICE
ت بر براز ر	2	<u>٩</u>	1 ☐ Yes 2 🔼 No 27. Manner of Death	28a. Date of Inju	ry 28	Outpatien b. Time of	28c. Injur	4 □ Nursing Ho	me 5 Resider 28d. Describe ho	-	ecity) House
Attending at death.		ţ	1 Accident 5 ☐ Pending investigatio	(Month, Da	y Year)	Injury	Wor	rk? Yes 2 □No			
Atten deal	2	Certification:	3 Suicide 6 Could not b	e 28e. Place of Inj	ury - At home	, farm, str	eet, factory, office	- T		reet and Number or F	Rural Route Number,
after Direction		erti	4 Homicide	building, et	c. (Specify)				City or Town	, State)	
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to an additional or the funeral precision of the funera	eny ille	Medical C	(Check only 2 Medical Exal	nysician: To the best miner: On the basis o	f examination	dge, death and/or inv	n occurred at the till vestigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner a ite and place, and du	is stated. le to the cause(s)
the I	india.	Med	one)	and manner sta	ated.		29c. Licens	se number	20	d. Date signed (Mog	oth Day Yearl
5 ± 5 5	8	_	29b. Signature and title of conflien	M. "	20		Zoo. Liberis	25284		3/22/	26
	ļ	i	I say pure	wh "			D-1-10	55-07		0/22/	
	and the state of t	11	30. Name and address of person who ANO NEA AU	completed cause of d	9 2/9	7 S	Wash	ington ?	St Ea.	ston m	0 26601
	Sta	e	31. Date filed (Month, Day, Year)		ar's Signature		1 3				
	ola: rietr		MAR 2	LUUD L		M	Aller I				

			tate of Marylan					_	
		_ State	iale of Marylan	•		of Death		211116	10785
26)		Registrar 1. Decedent's Name (First, Middle, Last)			Timouto	or Bouirr	2. Date of De	Reg. No.	3. Time of Death
Physicia		Evelyn Virginia	Hamilton				Month	24 200	09:70 M
/Medic Examin		4a. Facility Name (If not institution, give stree			4b. City ₉ To	wn, or Location of Death	0_)	4c. County of D	eath
LXamiii		SACRIAD HIART	HOSPITAL		Cil	MRIFRIANIA		A11176	ANIY
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I) If Under 1 \ Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Bird (Month, Da	th 9. I	Birthplace (State or Foreign Country)
Director		220-10-0498 1	20 X F 91	Yrs.		-,-	Month, Da	, 1915 We	Country) est Virginia
and w	ŀ	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or L	ocation				10d. Inside City Limits
Maryl f eho	ō	MD. Garrett	Bl	comin	gton				Maryes 2 No
1 the	rec	10e. Street and Number	1		10f. Zip Co	ode		10g. Citizen of What	Country?
be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. d other than "netural", or items 23s or 28s-f show event, the Medical Examiner must be notified at	Funeral Director	62 Brick Row, Box 5	57		21	523		United St	ates
deat	ner	11. Marital Status 12.	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Deceden	t of Hispanic Origin? (Sp. Cuban, Mexican, Pueno	ecify Yes or No Rican, etc.)	14. Race - A Black, W	merican Indian,
or It		1 Never Married 2 Married	I □ Yes 2 😿 No If Yes, Give		1 ☐ Yes 22		,	1	white
hours ural',	d by	3 Dividowed 4 Divolced	Year or Dates:	16a Daar	adont's Havel C	lanua ation		16b. Kind of Busine	and advetage
n 72 n 72	lete	15. Decedent's Education (Specify only highest grade co	mpleted)	(Give	edent's Usual C e kind of work o DO NOT use i	lone during most of work etired)	ing		
withi Bne. than	Completed	Elementary/Secondary (0-12) unknown	College (1-4or 5+)		nemaker			Housewor	ĸ
be filed within 72 h Ital Hygiene. Id other than "netu event, the Medical	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	, Maiden Sumame)	
lid be lental rked	To B	Edward Cheshir	e			Carı	rie Ri	ggleman	
shou and N		19a. Informant's Name/Relationship (Type,				treet and Number or Rur.			e, Zip Code)
and 2 palth a		Agnes Smith/daught				Ave., Luke,	Maryla	nd 21540	
permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens (important: If item 27 is marked other than "in eny Injury or other treumatic event, the Medical Conce.		20a. Method of Disposition ★XBurial 2 ☐ Cremation 3 ☐ Remo	C	ametery cre	osition (Name ematory or othe	rniace) \ \O_2 / '	Date 28/	20c. Location - City	
Pag ment ent:		4 □Donation 5 □ Other (Specify)	BTO		con Cem	ecery 200	5	_	n, Maryland
epart epart nport ny Inj		21. Signature of Funeral Service Licensee	110			Address of Facility Boo			
g ∪ = 9 d		I -way	3 at			rch St., Wes			
		23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the death ause on each line.	n. Do not er	nter the mode o	f dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	Septice		4				4 days
/Medical Examiner		f	Due to (or as a consequ	uence of):					
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	uence of):					
be executed sicien end burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
be executed icien end burial-transi	Exa	resulting in death) Last	Due to (or as a consequ	uence of):				· · · · · · · · · · · · · · · · · · ·	
9 % 9	cai	d							
Physician: The law requires that the death certificate this certificate this certificate has been signed by the ettending physical director, page 2 should be detached for use es the the thing the things of the th	Physician/Medi	IF FEMALE:							
ith ce itendi or use	an/l	23b. Was decedent pregnant in the past 13 months?	If yes, outcome of pregna 1□Live birth 2□Fetal	death 3	□Ectopic preg	nancy		23d. Date of Month	delivery Day Year
the ed	sici	1 Ves 2 Miles	4□Pregnant at time of do 9□ Unknown	eath 5	Other (speci	fy)		Month	Day Tour
res that the de signed by the e i be detached f		Part II. Other significant conditions contrib	uting to death but not resi	ulting in the	underlying caus	se given in Part I	23e. Did t	obacco use contribut	e to the cause of death?
signe d be	d by		rteny Dis		, ,			Yes 2 □No 3 □	,
w requir been si should I	ete	2 /	7.10			9	24a. Was	20 24h Word	a autoneu findinge available
he lav	Completed	Hent Failure					autop	ormed? death	
in: Tilicete or, pa	မ င်	25. Was case referred to medical				26. Place of Deat	1 Yes		/es 2□ No
s cert	To B	examiner?	nital: Mapatient 2	ER/Outpatie	ent 3 DOA	Other		dence 6 Other (5	Specify)
er thi			8a. Date of Injury (Month, Day Year)	28b. Time Injury				how injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ath. Pe fur	atlo	1 Accident 5 Pending investigation	(Month, Day 7 dai)	,	М	1 ☐ Yes 2 ☐ No			
r Atte	Certification;	3 Suicide 6 Could not be determined	8e. Place of Injury - At he building, etc. (Specify	me, farm, s	treet, factory, o	ffice	28f. Location (City or To	Street and Number of wn, State)	Rural Route Number,
To the Hospital or Attending Physician: The law within 24 hours efter death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2.									
Hosp 14 hou Fune Telly fil	Medical	(Check only 2 Medical Examiner:	en: To the best of my kno On the basis of examina	wledge, dea tion and/or i	ith occurred at nivestigation, in	he time, date and place, my opinion, death occur	and due to the red at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
the thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29c I	icense number		29d. Date signed (M	onth Day Year)
¥ ¥ ¥ 8	(()							1 1	
/		30. Name and address of person who comp	etad cause of death (Ita-	27a\ /T		21244		3/24/2	2006
5		Dr. Jesus Tan	Route 36	, Fr	ost bor	Plaza,	Frost	- burg, Mr	21532
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		J 31 DOI	3			
Registr		MAR 2 7 200	6	As a	Small o				

			For State	State of Marylar	nd / Depa		ealth and M	lental Hygie	ne	10786
			Registrar 1. Decedent's Name (First, Middle, Las	t)	- 001	imeate of t	Jean	2. Date of Death	No. UUU	3. Time of Death
	Physici /Medio		JAMES EDWIN HOBBS					03 a	Day Year	1320 M
7	Examir		4a. Facility Name (If not institution, give	, , ,		4b. City, Town, or	Location of Death		4c. County of Death	
	Funeral		5. Social Security Number 6. Se	nal <u>Medical</u> ox 7. Age (In yrs.	(ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Wicom	co
	Funeral Director		214-10-6023	XM 2□F 89	Yrs.	Months Days	Hours Min.	(Month, Day, Ye 12-09-191	6 MARY	place (State or Foreign intry) LAND
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	Maryl	ţō	MD WICOMI		ALISBUI					Y□Yes 2□No
	or 28s	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	untry?
	23e	rai	514 BUENA VISTA A	· · · · · · · · · · · · · · · · · · ·			21804		USA	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Healih and Menial Hygiene. If Itam 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, the Mardical Examinarity and be inclined at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? Wayes 2 No AR If Yes, Give Year or Dates: WWI	IM X	Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2 XNo	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: WH	
2 2	72 hor	Completed	15. Decedent's Ed		16a. Dece	dent's Usual Occupa	ation furing most of worki	na 16b	b. Kind of Business/li	ndustry
121	within ane. than	mpi	Elementary/Secondary (0-12)	College (1-4or 5+) 4	life.	DO NOT use retired CTRICAL E)		ELECTRICA	т.
о 5	Hygie Other ont,		17. Father's Name (First, Middle, Last)	4		CIRICAL E		(First, Middle, Maid		
<u>lan</u>	uld be Vental irked o	To Be	WOODLAND PAGE HOE	BBS			ANNIE LEI	GH HOBBS		
Maryland 21215-0036	2 should and Mer is marke raumatic		19a. Informant's Name/Relationship (7						ty or Town, State, Zi	
e,	1 and Health am 27 ther tr		AFTON H. HOBBS -	20b. F	Place of Dispo	sition (Name of			MARYLAND Location - City or T	
Baltimore,	permit. Pages 1 and Department of Healt Important: if Itam 2 any Injury or other ance.		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery, crer	natory or other place EMETERY	9) 03-24-		LISBURY, M	
a ⊒	mit. F partm portar y Injui		21. Signature of Funeral Service Licen				s of Facility BOU		RAL HOME,	the state of the s
<u> </u>	8258		1 June /2	Kelly					RY, MARYLAN	D 21804
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	dications that caused the deat	th. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Pvo to:	te	(oul	1			
ı	Examiner			b 10 (01 as a consec	(derice or).					
	p #	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consac	rienne of):					
	sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence)	juence of);					
_		calE		d.						
89	rtificat ng phy as th		IF FEMALE:							
Box	The law requires that the death certificate tite has been signed by the attending phy baga 2 should be detached for use as the	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	Il death 3	Ectopic pregnancy			23d. Date of deliv	rery Day Year
o <u>.</u>	that the de ed by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time of o 9□ Unknown	leath 5	Other (specify)	· · · · · · · · · · · · · · · · · · ·			52)
<u> </u>	res that i igned by be deta	y Ph	Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause give	on in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ğ	w require been sig should b	ted t	Diabetes u	mellin				1 🗆 Yes	2 □ No 3 □ Pro	bably 4 □Unknown
Records,	e law re has be ga 2 sho	Completed						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
_								performed	? death? No 1 ☐ Yes	2□ No
Vita	ysician: The is certificate hi director, paga	To Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☐ Ho	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Othe	26. Place of Death		6 ☐Other (Speci	(4.1)
פֿר	£ ⊊ ਜ਼		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe how in		19)
Sio	Attending at death. ector: After by the fune.	catic	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		,,		res 2 □No			
Division of	after deatl Director: Jin by the	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str (y)	eet, factory, office	1	28f. Location (Stree: City or Town, St	t and Number or Rur tate)	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by		29a. Certifier 1 Certifying Phy	vsician: To the best of my kno	wledge, death	n occurred at the tim	e, date and place, a	and due to the cause	e(s) and manner as	stated.
	the Ho lin 24 the Fu	Medical	one) 2 Medical Exam	iner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my op	oinion, death occurre	ed at the time, date	and place, and due t	to the cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	2	•	29c. License	number	29d.	Date signed (Month,	Day. Year)
•	13		30. Name and address of person who of	ompleted cause of death floor	n 23a) (Tune	Print)	1676)	4 1	(20107)	
	170		J & Cockey		346	1. 0.	11/m	14. 5.	alisba	m dzissy
	Sta Registr		31. Date filed (Month, Day, Year)	32. Begistrar's Signa	ature)		

1			For State Registrar	State of Ma	-	-	rtment tificate			and M	R	eg. No.	06	0.7	87
	Physici	an	1. Decedent's Name (First, Middle, La.	•							2. Date of Dear Month	th Day	Yeer	3. Time o	
	/Medic	al	Stanley Jone				45 Cit. 7		1ti	4 Death	Mac	1 -t-	2006 ounty of Death	0847	rj M
1	Examin	er	4a. Facility Name (If not institution, give	1 1 11.12	al Cente	-	4b. City, I	-	Location o			40.00	NA		
	-		5. Social Security Number 6. S		(In yrs. last bir		If Under		If Under		8. Date of Birth	1	9. Births	lace (State	or Foreign
	Funeral Director			™ 2□F		Yrs.	Months	Days	Hours	Min.	(Month, Day) DEC • 01	Yeer)	Cou	INGTO	
	P		Usual Residence of Decedent											0.1 1.11.1	Stern I transfer
	show	_	10a. State 10b. County		10c. City, Town									0d. Inside (s 2 No
	889-f	ecto		GEORGES	BRAND	DAMT	1	0-4-				On Citima	n of What Cou		
	with t	١	10e. Street and Number 12615 LUSBYS LAN	· ·			10f. Zip		20613				ED STA		
	leath	eral	11. Marital Status	12. Was Decedent B	ver in U.S.	13. V	Vas Deced			gin? (Spe	cify Yes or No- Rican, etc.)		. Race - Ameri	can Indian,	
(0	ifter deal	by Funeral Director	1 ☐ Never Married ※X Married	Armed Forces? 1 □ Yes 🛣 N		1				, Puerto I	Rican, etc.)		Black, White, pecify: BLA		
93	72 hours after death with the Maryland natural', or Items 23a or 28e-f show disal Existified at		3 Widowed 4 Divorced	tf Yes, Give Year or Dates:		<u> </u>	☐ Yes 🗶	(IV) NO	Specify:				pecify: DIJ	101	
21215-0036	72 h	Completed	15. Decedent's En (Specify only highest gra	ducation de completed)	16a.	(Give I	ent's Usual kind of work OO NOT use	k done d	lurina most	t of worki	ng	16b. Kind	of Business/In	dustry	
121	within ene. than	m d	Elementary/Secondary (0-12)	Coltege (1-4or 5	+)		RODUC					c	AFEWAY		
	e filed within al Hygiene. I othar than vent, I've Ma	ပိ	17. Father's Name (First, Middle, Last,			P	KODUC	E UI		er's Name	(First, Middle, I				
an	Mental Merked o	To Be	FRANCIS I. JONES						SHI	RLEY	A. JONI	ES			
Maryland	COFF		19a. Informant's Name/Relationship (Type, Print)	19b	. Mailin	g Address	(Street a	nd Numbe	er or Rura	l Route Number	r, City or T	own, State, Zip	Code)	
	and 2 si salth an n 27 is r er traur		DOREEN JONES / W	IFE			LUSE		ANE		RANDYWII				
ore	of He		20a. Method of Disposition XIXI Burial 2 Cremation 3	Removal from State	20b. Place of cemeter	f Dispos	sition (Nam natory or ot	ne of ther place	9)	0	ate	20c. Loca	ition - City or To	own, State	
Ë	Pag Iment tent: jury o		* 4 ☐ Donation 5 ☐ Other (Specif	y)	RESURF					THE PARTY OF THE PARTY OF			TON, M		
Baltimore,	permit. Pages 1 and Department of Healt Importent: If Itam 2 any injury or other 20059.		21. Signature of Fymeral Service Lice	austll	<u></u>		4308	SUL	LAND	_ROA		LAND,	RYLAND MD 20	74	
			23a. Part . Enter the disease, or com shock or heart failure. List only	plications that caused one cause on each lin	the death. Do	not ente	er the mode	of dying	, such as	cardiac o	r respiratory arr	est,		Approxima Interval Be Onset and	etween
	Physician		tmmediate Cause (Final disease or condition resulting in death)	a. Dilated	Cardior	nyor	outhy								
	/Medical Examiner		T assume the second sec	Due to (or as	a consequence	of):									
		e.	Sequentially list conditions, if any, leading to immediate cause. Each Uncertainty Cause (Disease or injury	b. Due to (or as	a consequence	of):									
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	c											
oʻ	ate be executed nysician and he burial-transit		resulting in death) Last		a consequence	of):									
8760	b × 6	llcal	•	d											
ø	leath certificate be execu attending physician and I for use as the burial-tra	by Physiclan/Medical	IF FEMALE:	23c. If yes, outcome	of progpagov						-	00	- O-A6		
Box	ath atter for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at	2 Fetal death		Ectopic pre					23	 d. Date of deliv Month 	Day	Year
P.0.	0 0 0	ıysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	and or dodar	3	Other (spe								
	s that the ned by th detache	۲ ک	Part II. Other significant conditions	ontributing to death be	ut not resulting i	in the un	nderlying ca	ause give	en in Part I.		23e. Did to	bacco use	contribute to t	he cause of	death?
rds	w requires that been signed to should be det	α pa									1 🗆 Y	es 2,🕱	No 3□Proi	oably 4]Unknown
ဝွ	law re as bee 2 sho	Completed									24a. Was a autops	sv l	24b. Were auto	psy findings	s available
R	0 = 0	ĕ									perfor	med? 2.24.No	death? 1 ☐ Yes	•	
/ita	ysician: Th is certificate director, pag	Be (25. Was case referred to medical examiner?							of Death	(Check only or	10)			
of \	Physician: this certific ral director,	၉	1 Yes 2 No	Hospital:		utpatient Time of		_	4 🗆 140		me 5 Residence 128d. Describe he			(y)	
Division of Vital Records,		lon	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injui (Month, Da)	Year) 200.	Injury	M	8c. Injury Work	rati (? Yes 2 □:	1	zad. Describe in	Ow Injury	occurred		
isi	Attanding ir death. actor: After by the fune	ficat	3 Suicide 6 Could not b	e 28e. Ptace of Inju	ury - At home, fa	arm, stre					28f. Location (S	treet and I	Number or Run	al Route Nu	mber,
Ο̈́	al or A after I Dira d in b	Certification;	4 Homicide determined	building, etc	c. (Specify)						City or Tow	n, State)			
	To the Hospital or Attanowithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medicel Exer	nysician: To the best oniner: On the basis of and manner sta	examination ar	e, death	occurred a restigation,	at the tim in my of	ne, date an pinion, dea	nd place, a	and due to the c ed at the time, c	ause(s) ar	nd manner as s lace, and due t	tated. o the cause	(s)
	To the within To the compl	Me	29b. Signature and title of certifier				29c	. License	e number		2	9d. Date	signed (Month,	Day, Year)	
			Frie M. B	own MD				PI	966	7		Mac	17	2006	
R	(10)		30. Name and address of person who Ecic Brown 2		eath (Item 23a)	(Type, I		Itime	ore, M	0 7	21201				
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 3 200	A Registra	ar's Signature	for									

State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner

attending physician ф as the t ģ pe sign t be been page 2 s certificate has director this in funeral After Hospital or Attending after death.

Director: Af
I in by the fur

Ö

Division of Vital Records, P.

JOHN ₹. MERCEROR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ONSEITIVE disease or condition resulting in death) Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events Due to (or as a consequence of): Iner Exami resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed 24a. Was an autopsy performed? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 ☑ 1√10 Medicai Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funerel (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) im 3 J'. EGLSEDER III 503 CYNWOOD DRIVE EASTON, MD 21601 LUDWIG M.D. 31. Date filed (Month, Day, Year) strar's Signature State MAR 24 Registrar ORIGINAL

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** HUGHIE H. JENSEN MARCH 21 11:45AM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 29308 SPRUCE PLACE EASTON TALBOT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) APR 19 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 F Months Hours GEORGIA Director 267-28-1779 94 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 Yes 2 □ No Director MD TALBOT EASTON 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 29308 SPRUCE PLACE 21601 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) REAL ESTATE Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER/ACCOUNTANT 12 0 DEVELOPMENT CO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be FRANCES KING EUZEMA H. CLEVELAND ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HADLEY JENSEN/HUSBAND 29308 SPRUCE PLACE, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 3/22/2006 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Approximate Interval Between Onset and Death 66AV 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Other: 4 Nursing Home X Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) t 🖯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

		For State Registrar	State of Mar	•	artment of H rtificate of I		d Mental Hy	rgiene Reg. No. 006	10789
Physici /Medic		1. Decedent's Name (First, Middle, Last, Dorothy V. Jones)				2. Date of Do Month March	eath 19, ^{Day} 2006 ^{Yea}	3. Time of Death 8:45
Examir		4a. Facility Name (If not institution, give Crofton Convalesce				Crofton		4c. County of De Anne Aru	
Funeral Director		5. Social Security Number 6. Set 217-24-8731 15 Usual Residence of Decedent	7. Age (In yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hours N	In. 8. Date of Bi		Birthplace (State or Foreig Country) YLand
Maryland -f ahow	tor	10a. State 10b. County MD Anne Aru		Oc. City, Town or Lo					10d. Inside City Limit
h with the 23a or 28a	al Direc	10e. Street and Number 3765 Oak Lane			10f. Zip Code 21037			10g. Citizen of What United Sta	
iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If the m 27 is marked other than "natural", or items 23a or 28a-f ahow or other traumatic event, the Maclical Examplar must be notified at or other traumatic event, the Maclical Examplar must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ Yo	ispanic Origin? in, Mexican, Pu Specify:	' (Specify Yes or No uerto Rican, etc.)	o- 14. Race - Al Black, W Specific k	merican Indian, hite, etc.
within 72 ho ene. than "natur ha Medical I	ompleted	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occup o kind of work done o DO NOT use retired	ation during most of	working	16b. Kind of Busine State Gove	
uld be filed Mental Hygi arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) William Henson					Name (First, Middle ine Butl	a, Maiden Sumame) _er	
and 2 sho alth and I 27 is ma er traums		19a. Informant's Name/Relationship (Ty Cori Coates / Gran			ng Address (Street a Oak Lane			per, City or Town, State 21037	e, Zip Code)
permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of Dispo cemetery, crea Bestgate	osition (Name of matory or other place Memorial	Park	Mar 24 2006	20c. Location - City Annapolis	
Departr Departr Imports any inju		21. Signature of Funeral Service Licens	1/1007	2	Mame and Address Miller S 1922 Fore	Metropo st Driv	olitan Char re Annap	apel olis, MD	
nysicia he bu	Ilcai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a condition of the conditi	consequence of):	var o		=		
0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 (4□Pregnant at tin 9□Unknown	Fetal death 3	□Ectopic pregnancy			23d. Date of o	delivery Day Year
iaw requires inal ine as been signed by th 2 should be detache		Part II. Other significant conditions con	ntributing to death but r	not resulting in the u	inderlying cause givi	en in Part I.			to the cause of death? Probably 4 \Qunkno
ate h page	Completed by	/					24a. Was auto perf 1 🗆 Yes		
ding Physician: The	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 No Natural 5 Pending investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatier 28b. Time o (ear) Injury	of M 28c. Injun Worl	er: 41 Nursin	7.	one) idence 6 Other (S how injury occurred	pecify)
5 # 5 =	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st 'Specify)	reet, factory, office			(Street and Number or own, State)	Rural Route Number,
Funeral I	edical		sicien: To the best of r ner: On the basis of ex and manner state	camination and/or in					
n 24	ž	29b. Signature and title of certifier			29c. License	e number		29d. Date signed (Mo	onth Day Yearl
To the rewithin 24 To the F	~	· Selv			73	8958 Hiphwi		3/21/0	06

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20: 46 M 2004 March ANNA M. KLEMPNER /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HICOMICO 34436414 KegloNas Medica TENINSULA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Days Hours Months 1□M 2□F MARYLÁND 07-06-1935 Director 70 220-32-1562 Usual Residence of Decedent within 72 hours after death with the Maryland 10c City Town or Location 10d. Inside City Limits 10a State 10h County r than "netural", or items 23a or 28a-f show the Mudical Examiner must be notified at ty∏Yes 2 ☐ No Director SALISBURY WICOMICO MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 301 N. PARK DRIVE by Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: WHITE Specify: 3 ☐₩idowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) OWNER RESTAURANT permit. Peges 1 and 2 should be filed v. Department of Health and Mental Hygien Important: If Item 27 ie marked other tenny injury or other traumatic event, IDS 20028. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HELEN MENZEL ALLEN MASSEY ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 106 WEST LONDON AVENUE, SALISBURY, MARYLAND 21801 ROBIN GEORGE - DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 21☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 03-25-2006 DELMAR, DELAWARE 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner NEUNUNI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical as the l y the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Dav in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown should peeu 24b. Were autopsy findings available prior to completion of cause of death? INFECTION 24a. Was an page 2 s hes autopsy 1 Yes this certificate 1 Yes 2X No Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hnpatient 2 ER/Outpatient 3 DOA မှ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide or A after 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) -006.0515 11. T/- IIMMARAYA PPA 31. Date filed (Month, Day, Year) SHORE 32. Registrar's Signature State MAR 2 3 2006 Registrar

				State of Maryla	nd / Depa	artment of	Health and N	Mental Hyg	giene	and the Pro-
		-	For State Registrar	,		rtificate of			Reg. No. () () ()	10792
	* " *		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	ith Day Yea	3. Time of Death
	Physicia /Medic	al	Ibrahim .	Lakra				Mar	15 2006	2515 M
	Examin	er	4a. Facility Name (If not institution, give		0	4b. City, Town,	or Location of Death		4c. County of De	eath
		**	Oniversity of Mary 5. Social Security Dumber 6.5	land Medica	(Center s. last birthday)	If Under 1 Year	iltimore If Under 24 Hrs.	8. Date of Birtl	n/A	Birthplace (State or Foreign
	Funeral Director			X M 2□F 74		Months Days	Hours Min.	(Month, Da) March 30	, Year)	Country) Idia
Ro**	3,-		Usual Residence of Decedent					1.2.2.011 30	,	
	rylan	_	10a. State 10b. County		City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 X No
	8a-f	Director	Maryland Prince G	eorge's La	nham	Tan 7: 0:4:			10g. Citizen of What	
	vith th	D Le	10e. Street and Number			10f. Zip Code			U.S.A.	Country
	eath ve 23	Funeral	7408 Varnum Stree	12. Was Decedent Ever in	U.S. 13.	20784 Was Decedent of	Hispanic Origin? (S	pecify Yes or No-	14. Race - Ai	merican Indian,
	r Item	F	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🔯 No		If Yes, specify Cu	ban, Mexican, Puerti	o Rican, etc.)	Black, W	
036	al', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	o Specify:		Specify:	Asian
20	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or iteme 23a or 28a-f show event, the Medical Exeminar must be notilised at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occi	e during most of wor	king	16b. Kind of Busine	ss/industry
21	han ne.	ld m	Elementary/Secondary (0-12)	College (1-4or 5+) 5+	Owne	DO NOT use retir	90)		Retail Sa	165
N B	Hygie ther t		17. Father's Name (First, Middle, Last		OWIIC	<u> </u>	18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
au	d be ental ked o	To Be	Anand Masih Lakra				Kunu Sid	lowni San	ncha	
Maryland 21215-0036	shou ind M mar umat		19a. Informant's Name/Relationship (Type, Print)					er, City or Town, State	
Σ	and 2 iaith a 127 ls		Abha Lakra - Wife				Street, La	_	aryland 20	
ore	of He		20a. Method of Disposition 1 X Burial →2 □ Cremation 3 □		cemetery, cre	osition (Name of matory or other pi		Date	20c. Location - City	
Ē	Pag tment tent: jury o		4 □Donation 5 □ Other (Speci	(y) Pa	the second second second second second	Cemeter			Rockville,	
Baltimore,	perrait. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Iteme 23a or 28a-f show any njury or other treumatic event, the Medical Examinar must be notified at ancie;		21. Signiture of Funeral Sen is Live	nsee,	2	2. Name and Add			Funeral Ho	ome, P.A. e, MD 20781
F			23a, Part1. Enter the disease, or com	plications that caused the d	eath. Do not en					Approximate Interval Between
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Onset and Death
.	Physician /Medical		disease or condition resulting in death)	a. Pancre Due to (or as a cons		Car	cer			
	Examiner		Comments the line and division	b						
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or se a none	requiance of):					
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					
760,	icate be executed physician and s the burial-transit	cal E)		D88 10 (0) 43 4 0011.	334331100 31).					
687	physicate sthe	edica		_ d						
Box (leath certificat attending phy I for use as th	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		De			23d. Date of	-
	the death certifica y the attending ph Iched for use as th	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregnar □ Other (specify)			Month	Day Year
P.0	that the de led by the a detached f	hys	9 Unknown					00- 0:44		a to the equal of death?
	og ped	þ	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause	given in Part I.			e to the cause of death? Probably 4 XUnknown
ord	w requir been si should	ted								
Vital Records,	has b	Completed						24a. Was autop		a autopsy findings available to completion of cause of h?
a F							20.01	1 ☐ Yes	2/No 1 1	Yes 2□ No
Ž	Physician: this certific at director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient	ER/Outpatie	ent 3 DOA	Ther:	ath (C <i>heck only c</i> Home 5 □ Resi	dence 6 □Other (5	Specify)
of			27. Manner of Death	28a. Date of Injury (Month, Day Yea					how injury occurred	,
Ö	Attending Is death.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigate	on	injury		□Yes 2□No			
Division	or Attendate death Director:	Certification:	3 Suicide 6 Could not 4 Homicide determine		At home, farm, s ecify)	treet, factory, offic	ж	28f. Location (City or To		r Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by		20 0 111	hysician: To the best of my	I	th against the	time date and also	and duals the	calleg(s) and man-	ur as stated
	the Hospitel hin 24 hours a the Funerel I mpietely filled	edical	29a. Certifier (Check only one) 1. Certifying F	mysician: To the best of my miner: On the basis of exam and manner stated.	nination and/or i	nvestigation, in m	y opinion, death occ	urred at the time,	date and place, and	due to the cause(s)
	within 2 To the complet	Me	29b. Signature and title of certifier				ense number		29d. Date signed (M	
			Y I mars In	onke r	M, Γ	P	19844		11 lar 13	5 2006
M	(5)		30 Name and address of person who		(Item 23a) (Type	, Print)	. 7	î ·	00	5 2006 and, 21201
-			31. Date filed (Month, Day, Year)	22 South	Green	e Stree	et, Dal	more	, Illaryla	and, dld01
18.	St Regist	ate trar	MAR 2 3 200		F As	W				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Amend Item #8 State of Mary Registrar WCHD/SH 3/30/06 per FH Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** MOHO dWARD 9:50 March 26 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and pumber) City, Town, or Location of Death Examiner Wastinjer HAGERSTOWN COUNTY MOSPILO WOSHINSTON If Under 24 Hrs. 8. Date of Birth 1 1/9/8 / 19 196 irtholace (State or Foreign (Month, Day, 1/9/a/r) 8 / 19 196 Country) Year 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2□ F Yrs 89 215-12-1991 Maryland Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location or 28a-f show the Medical Exeminer must be notified at 1 □Yes 2X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 17900 Pin Oak Road 21740 USA death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: items! Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò Specify: White 1 Tes 21 No Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) grade completed (Specify only highest other than College (1-4or 5+) Elementary/Secondary (0-12) 12 Engineer Structura1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event 908. Be Dicey Valine Blizzard ည Calvin D. Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17900 Pin Oak Road, Hagerstown, Md. 21740 Jane B. Long/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery 3/29/2006 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Liounsee 1601 Pennsylvania Avenue, Hagerstown Md. 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MUDCARDIDI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed ANEMIA Exami attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No Q No 1 🗌 Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Certification; To 1 🗆 Yes 2 XN0 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death the Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours after To the Funeral Dire Hospital 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 25)

MD

HOSPITOIS

32. Registrar's Signature

BARAN

31. Date filed (Month, Day, Year)

			1 - State Registrar		artment of Health and N rtificate of Death	Reg. No).
	Physicia /Medic		Decedent's Name (First, Middle, Last) HOWARD FRANKLIN LONG			2. Date of Death Month Da MARCH 23	2006 11:12 A ^M
	Examin		4a. Facility Name (If not institution, give street and number) 101 YOUNG AVENUE 5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	4b. City, Town, or Location of Death BOONSBORO If Under 1 Year If Under 24 Hrs.	8. Date of Birth	: County of Death WASHINGTON 9. Birthplace (State or Foreign
	Funeral Director		000 00 0071 18 M 2 T F	79 Yrs.	Months Days Hours Min.	NOV. 5, 19	Country)
	death with the Maryland ms 23s or 28s-f show r must be notified at	Funeral Director	10a. State 10b. County 10c MARYLAND WASHINGTON 10c 10e. Street and Number 101 YOUNG AVENUE	c. City, Town or Lo	BOONSBORG		10d. Inside City Limits 1 1 Yes 2 □ No itizen of What Country?
5-0036	urs efter el', or ite Exemine	þ	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ No □ □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ □ No □ □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □ □ No □	in U.S. 13. 1944– 1946	Was Decedent of Hispanic Origin? (Siff Yes, specify Cuban, Mexican, Puerli 1☐ Yes 2☑ No Specify:	pecify Yes or No- o Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: WHITE
)-61212	within 72 ene. than "na	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12	(Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) RIALS ENGINEER	king	STATE GOVERNMENT
yland	should be filed nd Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) JOHN WELLINGTON LONG SR.	1111111	18. Mother's Nan	ne (First, Middle, Maide) M. CLOPPER	
e, mar	1 and 2 Health a em 27 la		19a. Informant's Name/Relationship (Type, Print) HOWARD W. LONG/SON 20a. Method of Disposition	14 DE	ng Address (Street and Number or Ru LLA LANE BOONSBO position (Name of	ORO, MARYLAI	
Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Buheral Service Licensee	BOONSBOR	matory or other place) O CEMETERY 03/2 2. Name and Address of Facility AST FUNERAL HOME	7606 01d r	ONSBORO, MARYLAND nationalPike
	Physician /Medical Examiner		23a. Part. Enter the dise of or complications that caused the shock, or heart failure. List only one cause on each line.	static			Maryland 21713 Approximate Interval Between Onset and Death 3 4ears
8/60,	The law requires that the death certificate be executed to has been signed by the attending physician and lage 2 should be detached for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any leadin to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a co				
O. Box 6	the death certific. y the attending piched for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of properties of the properties of the properties of properties of the properties of th	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
7	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death but que Hypur Hens/on	ot resulting in the u	inderlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
Vital Records,		Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 X No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
5	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page.	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending (Month, Day Ye) 2 Accident investigation	2 ☐ ER/Outpatier 28b. Time o Injury	nt 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Sescribe how inju	
DIVISION	tal or Attendi rs after death. al Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury-building, etc. (S	At home, farm, str pecify)	reet, factory, office	28f. Location (Street a. City or Town, Stat	nd Number or Rural Route Number, e)
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of m 2 Medicel Exeminer: On the basis of exa and manner stated.	mination and/or in	vestigation, in my opinion, death occu	rred at the time, date an	d place, and due to the cause(s)
	F 3 F 8		30. Name and address of person who completed cause of death 24 A MAIL MD 20 Society of the state of the sta	(item 23a)/Type	D44996	Ma	nch 24, 2006
5H	-20+1 Sta		2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Signature	pans ita Ba	instro M	10 2/113
	Registr	ar	TIMIN & / / III	Di.	A		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month VERNON DANE LINTON March 22, 2006 a00:8 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1012 Cedar Street Pocomoke City Worcester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, March 24, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ¼** M 2□F Year) Director 227-24-1040 80 Yrs. 1925 Virginia Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or fleme 23a or 28e-f ehow the Medical Examiner must be notified at 1 XYes 2 No Director Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 Cedar Street 21851 Funeral USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white WWII Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Laborer Utilities es 1 and 2 should be filed to the substitution of Health and Mental Hygie filem 27 is marked other rother traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ Vernon Linton Susie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Linton (son) 1624 Cedar Hall Rd., Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages nent of h 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Depertment of important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Downings Cemetery 3/25/2006 Oak Hall, Va. 21. Signature of Fun-val Service Licensee Holloway Melson Funeral Home, P.A. Michael 103 Linden Ave., Pocomoke City, MD 21851 ean 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Sudder Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of): Examiner VA 50 Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine 0 ned by the attending physicien end detached for use as the burial-transit The law requires that the death certificate be executed 40 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2€No 1□ Yes To the Hospital or Attending Physicien: : After this certific a funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending s efter death. 1 ☐ Yes 2 ☐ No investigation NIA 2 Accident 3 Suicide 6 Could not be determined within 24 hours efter de To the Funeral Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of per w who completed cause of death (Item 23a) (Type, Print) DN 5+ Market 00 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

MAR 2 4 2006

			1 - For State Registrar		f Marylan	nd / Depa		t of H	ealth a		ental Hy		nno		10796
	v z w		Decedent's Name (First, Middle, Last	st)			-]	2. Date of Dea	ath			3. Time of Death
	Physici /Medic		Mary Emily Long	5							March_	28,		/ear	10:10P M
	Examin		4a. Facility Name (If not institution, give		n <i>ber)</i>		4b. City,		Location o				County of		
.10	al · · · · · · ·		St. Mary's Hospi 5. Social Security Number 6. S		7 Ago /lo um	(not histhday)	If Under		nardt If Under 2		9. Date of Birt		St. M		
	Funeral Director		217-66-0378 Usual Residence of Decedent	_M 2 X F	7. Age (In yrs.		Months		Hours	Min.	8. Date of Birt (Month, Da Aug 31				lace (State or Foreign try) 1and
	hours after death with the Maryland tural, or ttems 23a or 28a-f show at Exacultat must be motified at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							1	Od. Inside City Limits
	e Ma	Director	Maryland St. Ma	ry's		A·	venue								1 ☐ Yes 2 No
	hours after death with the Marylar tural; or flems 23s or 28s-f show al Evantuer mind to notified at		10e. Street and Number				10f. Zip	Code				10g. Cit	izen of Wh	at Coun	itry?
	eath v	erai	37390 Riverspri		edent Ever in U	S 13 1	Was Deced		609	nin? (Sne	ofy Ves or No		US 14. Race		an Indian
_	r fterr	Funerai	1 ☐ Never Married 2 ☐ Married	Armed Fo 1 ☐ Yes	rces? 2 🕅 No					, Puerto I	cify Yes or No- Rican, etc.)		Black,	White,	etc.
3	ral', o	by	3 Widowed 4 □ Divorced	If Yes, Giv Year or D			1□Yes 2	2 1 No	Specify:				Specify: \	vnit	e
215-0036	hin 72 ho e. In "natur Medicel	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	kind of wor	rk doné d	urina most	t of workii	ng	16b. K	ind of Busi	ness/Inc	dustry
7	within 72 ene. then "nat	mpi	Elementary/Secondary (0-12)	College (1	-4or 5+)		onema.	-)			0		_	
N 0	filed Hygie ther ant,	e Co	17. Father's Name (First, Middle, Last)				omema.	Kel	18. Mothe	r's Name	(First, Middle,		n Hom		
land	ld be ental ked o	To B	Thomas Vichery ()liver					Marv	Whi	ttingha	m Cl	hecel	dina	•
aZ	shou and M mar umat	-	19a. Informant's Name/Relationship			19b. Mailin	g Address	(Street a	100		Route Numbe				
, Mai	and 2		Melanie Lynn Poole /	Daughter		37380	Riv	ersp	ring	Road	Avenue	MD	2060	9	
saitimore,	ges 1 and 2 should tof Health and Mer If Itam 27 is marks or other traumatic		20a. Method of Disposition 1	Removal from	State 20b. F	Place of Dispo cemetery, cren	sition (Nam natory or ot	ne of ther place	a)	D	ate	20c. Lo	ocation - C	ity or To	wn, State
	Pages tment of I tant: If its jury or o		4 □ Donation 5 □ Other (Specify	()	Sac	cred Hea					, 2006	Bus	hwood	, MI)
g D	Departi Departi Important Any in		21. Signature of Funeral Service Licer	in Has	dineis	1.	Matt:	ingle Box	y-Gard 270, L	iner eonar	Funeral H dtown, MI	Home,	P.A. 50		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that o	aused the deal										Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a	7450	KIC ?	2526	1)4	te (7	7	21114	Ye		. 81	1)4+1
	/Medical Examiner		resulting in dealin)	Due to	(or as a conseq	uence of):			c 4	6	11452				17975
	3. 35	e	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a conseq	uence of):	6 0	4 4	/ 1	14	11402			-	
	d d ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0	HIPE	s tens	Iun								Years
Ď	ate be executed hysicien and he burial-transit	Exa	resulting in death) Last	Due to	or as a conseq	uence of):		11 -	4, 1						46465
8/60	ate be	dical	•	d	196	tes	ne	/ / /							
õ ×	certifica Iding ph	/Mec	IF FEMALE:	220 Hyge out	come of pregna	anou.									
X Q Q	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live b	irth 2 ∏ Feta ant at time of d	I death 3	Ectopic pre						23d. Date Month		ry Day Year
j.	t the d by the ached	hysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9□ Unkn				,,	·						
r Š	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions of	ontributing to de	ath but not res	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco u	se contrib	ute to th	e cause of death?
cord	equire en sig										1 🗆 Y	es 2	□No 3	☐ Prob	ably 4 QUnknown
ပ္သ	law ras be	ompieted									24a. Was		24b. We	ore autor	osy findings available
	: The law cete has page 2 s	Con									perfoi 1 □ Yes	med?	dea	ath?	No No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho			Check only o				
5	Phys this ral dii	. 70	1 Yes 2 No	28a. Date		ER/Outpatien 28b. Time of		8c. Injury	4 Nur		ne 5 Resid				')
0	Attending Phyrdeath.	ertification:	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Mon	h, Day Year)	Injury	м	Work	? ′es 2 □ N			ow injur	y 000u1100		
VISION	or Attandatter deatt Director: In by the	ifica	3 Suicide 6 Could not be determined	28e. Place	of Injury - At he	ome, tarm, stre	eet, factory,	, office		2	8f. Location (S	treet an	d Number	or Rura	I Route Number,
_	5 C	Cert	4 - Horniciae	buildi	ng, etc. (<i>Specif</i>	у)					City or Tow	m, State)		
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a Certifier 1 Certifying Ph (Check only 2 Medical Examone)	niner: On the b	best of my kno asis of examina ner stated.	wiedga, daath ition and/or inv	conturad a vestigation,	in my op	s data and inion, deat	d place a	nd die to the o d at the time, o	date and	and man d place, and	ar as st d due to	ated. the cause(s)
	To t withi To til	Ň	29b. Signature and title of certifier	M	-			. License					le signed (
			Military	>			()	00	617	19		3	129	10	G
			30. Name an address of person who												
10		110	Dhananjay V. Bh 31. Date filed (Month, Day, Year)		M.D. S gistrar's Signa		socia	tes	Ho11	wood	MD 2	0636		-	
	Sta Registr	77.0	MAR 3 0 2				المقاع								
		5		300	September 1									-	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 23 2006 Physician 7:45 A M Louis Almancia /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3806 Shetland Court Frederick Frederick If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Months Days Hours 1 □ M 2 13 E 71 069-84-7423 Haiti 5, Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 3806 Shetland Court 21704 Haiti death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Itema Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anara Laverdure ဥ Magloire Jean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3806 Shetland Ct. Frederick, MD 21704 Grace Charitable / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition March 30, 1 ☐ Burial 2 ☐ Cremation 3 反 Removal from State 2006 Plaisance, Haiti 4 ☐ Donation 5 ☐ Other (Specify) Plaisance Cemetery 21. Signature of Fusifal Service License 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part1. Exertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Myocardial Ischemia Hours **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Month Pancreatic Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached to 1 ☐ Yes 2 ☐ No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 25 No 3 Probably 4 Unknown Completed Cancer Cachexia certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Injury 1. ₩Natural 5 Pending 1 Tes 2 No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 23, 2006 D 44164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Z. Hegazi, M.D. 46-B Thomas Johnson Drive, Frederick, MD 21702 31. Date filed (Month, Day, Year) MAR 2 State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2006 MARCH 10:45AM M HARRY W. LARRIMORE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M X F 84 Yrs. DEC 19, MARYLAND Director 215-14-7377 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthan "natural", or items 23s or 28s-f show the Modical Examiner must be notified at 1 Yes 2 □ No Director TILGHMAN MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21671 USA 4906 BAR NECK RD death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ss 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", or Iter Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) CAPTAIN CHARTER BOAT 8 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY ROE HARVEY W. LARRIMORE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMBERLY A. JONES/GRANDDAUGHTER PO BOX 52, WITTMAN, MD 21676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 nent of H ant: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) TILGHMAN MEMORIAL CEM 3/27/2006 TILGHMAN, MARYLAND 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA MERCERCA 200 S. HARRISON ST EASTON, MD 21601 JOHN R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lunacancer Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to innreciate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dula to for as a consequence of). The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ettending physic IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes fo the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of Injury Date of Injury (Month, Day Year) 27. Manner of Death Certification: Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death.

Director: Af
d in by the fur 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wereiBeh, MD D46052 3/22/06 pleted cause of death (Item 23a) (Type, Print) Parhway, annatho, MD Strend Bech, MD GHIVA 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HORACE M. LOWMAN. SR. MARCH 23 2006 1400 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death WILLIAM HILL MANOR EASTON TALBOT 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Days Hours Months Director 212-10-2331 93 Yrs DEC 29, 1912 MARYLAND Usual Residence of Decedent 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "neturel", or Items 23e or 28e-f shov treumatic event, the Mudical Examinat must be notified at Director Yes 2 No TALBOT EASTON death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 2 should be filed within 72 hours after of and Mental Hygiene. is marked other then "neturel", or Iter Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █No Specify. þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) O POLICEMAN LAW ENFORCEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be TRUMAN M. LOWMAN 2 EDNA PEARL HOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i other tre HORACE M. LOWMAN, JR./SON 28705 EMANUEL ST., EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State \$ = 6 1 ▼ Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) Department of Importent: If eny injury or once. PROSPECT CEMETERY 3/28/2006 MT. AIREY, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA S CHOL MERCERON 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician neumorua 3 days /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or). Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, Physiclan/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Þ in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. 1 Yes 2 No the 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe heart failure page 2 should Be Completed 2 🗌 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2000 certificate 1 🗌 Yes 2 🗆 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 → No Hospital: Other: 4 Arursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending after death death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 T Homicide 24 hours a Funerel I Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

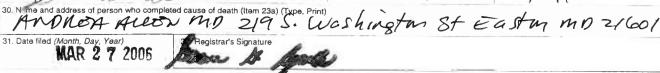
29b. Signature and title of cartific

Medical

State Registrar

completely

To the



ORIGINAL

D35284

29d. Date signed (Month, Day, Year)

3/24/06

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Рм 03-19-2006 2:45 CHARLENE G. MUNDELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10–10–1960 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖵 F 577-90-6234 45 Washington, DC Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "netural", or items 23a or 28a-f show the Medical Exemples from the nutified at Maryland Prince George's Capitol Heights 1XXYes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 1316 Dunbar Oak Drive USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th Cook Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 Is marked of Lawrence Mundell Queenie Foreman P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Queenie Foreman/mother 2310 Southern Ave., SE Wash., DC 20020 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crem. 03-28-2006 Riverdale, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mo1453 Cedar Hill FH Inc. 4111 Penn., Ave. Suitland, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner consequence of) death certificate be executed use as the burial-transi attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year ţ Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached t P.0. signed I Part II. Other significant conditions contributing to death but not 23e. Did tobacco use contribute to the cause of death? resulting in the underlying cause given in Part I Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy certificate Yes 25. Was case funeral director, 26. Place of Death (Check only one) examiner 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes P 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Mapher of Death Certification: After Hospitel or Attending Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29d. Date signed (Month Day, Year) 29c. License number 29b. Signature and title of certifier e and advess of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 3 2006

			For State Registrar	State of Marylan		artment of rtificate of			giene Reg. No.	006	10803
N.	Physicia	ın	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year 2001a	3. Time of Death
	/Medic Examin	-	Freda Mae Moc 4a. Facility Name (If not institution, give st			4b. City, Town,	or Location of Death		4c. C	ounty of Death	
	Funeral Director	51	Doctor s Hospi 5. Social Security Number 219-10-0683 Doctor s Hospi		last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day May 1,	h / Year)	9. Birth	George's place (State or Foreign ntry) ry1and
	ryland how Lat		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Ma-f s	Director	DC			Wash	ington				1 XYes 2 No
	n the	ire	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?
	th wil		1528 Fort Day	is St., S.E.			20020		1	United	States
M48 5-0036	*natural; or Iteme 23a or 28a-f show	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto o <i>Specity:</i>	pecify Yes or No- Rican, etc.)		Race - Ameri Black, White, pecify: B	
5-0	72 h	etec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occu	upation e during most of worl	king	16b. Kind	of Business/Ir	ndustry
21	within ene. then	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.		e during most of worled)				
4 2	ygier rer th	So	12th			Custodi	al Work			Privat	e
S E	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	·			
X B	Ment	ဂ္	Unknown		_			Pauli	ine Re	ocheste	r
Maryland,	Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other then irry or other traumatic event, ILEM irry or other traumatic event, ILEM irry or other traumatic event, ILEM irry or other traumatic event, ILEM irry or other traumatic event, ILEM irry or other traumatic event, ILEM irry or other traumatic event, ILEM irry or other traumatic event, ILEM irry or other traumatic event, ILEM irry or other traumatic event, ILEM irry or other traumatic event.		19a. Informant's Name/Relationship (Type Robin M. Berger	· . · · ·			ers Pl., F				
Mooke Baltimore,	Pages 1 ament of He ant: If Iten jury or oth		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	emetery, cre	sition (Name of matory or other pl Memoria1	ace) Park 3/2	Date 2 / 2006		ution - City or T andover	
	그 문문을 .		21. Signalure of Funeral Service License			2. Name and Add		Stewart			
Ba	Depa Impo eny in		▶ \nl) T. < \$	ewart III		4001	Benning				
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Jause (Final	ations that caused the deat e cause on each line.		er the mode of dy	ring, such as cardiac				Approximate Interval Between Onset and Death
	Physician / /Medical	1	disease or condition resulting in death)	RESPIR Due to (or as a conseq	 	PAIC	-URE				24 Hours
68760,	ificate be executed g physicien and strengthe burnal-transit as the burnal-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	uence of):	EPILEP'	TICUS				24 Hours
87	ate hysi	edical	d.								
Вох	Attanding Physician: The law requires that the death certific rolesth. ector: After this certificate has been signed by the attending pot the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown	lc. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	death 3	Ectopic pregnan Other (specify)	су		23	d. Date of deliv	rery Day Year
ds, P.O	uires that i signed by id be deta	ρ	Part II. Other significant conditions conditions CONDEHYDRATION		ulting in the u	nderlying cause g	jiven in Part I.		bacco use		the cause of death?
Ö	w require been sig	lete	RENAL FAI	14.22				24a. Was a	an	24h Wara aut	opsy findings available
l Re(The lav	Completed	KENAL I-AI	LUICE				autop perfor	rmed?	prior to co death? 1 \(\sum \text{Yes}	ompletion of cause of 2 № No
ita/	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	20.04				th Check only or	ле		
~	hysic I dire	ို	1 ☐ Yes 2 📉 No	ospital: 1 Anpatient 2	ER/Outpatie	nt 3 DOA	ther: 4 Nursing H	ome 5 Resid	ience 6 (Other (Speci	fy)
o uc	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	ury at ork? □ Yes 2 □ No	28d. Describe h	now injury	occurred	
Division of Vital Records,	i Sir e	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st (y)			28f. Location (S City or Tow		Number or Rui	al Route Number,
	o the Hospital ithin 24 hours a o the Funeral (edicai (ician: To the best of my kno er: On the basis of examina and manner stated.							
	o the	Me	29b. Signature and title of certifier	ew , M.D.			nse number		29d. Date	signed (Month	, Day, Year)
							17004		03	12010	16
CR	4)		30. Name and address of person who could be supported by the support of the suppo	MUTTAH H.	n 23a) (Type,	Print) 03 Qu.	LENSISJKY	ROAD	Hy.	+775V10	LE, MO 2078
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 3 2006	32 Registrar's Signa	ature	all a					
DH	HMH 17 Rev 1/20	001		1	19						

			1 - For State Registrer 1. Decedent's Name (First, Middle, Las	State of Ma	ryland / De	epartme		ealth and	Mental Hy	Reg. No.	10804
	Physicia /Medic Examin	al		Harry MOO	RE		ity, Town, or Hagerst	Location of Dea		26, 2006 Year 4c. County of Death Washingt	
	uneral irector		5. Social Security Number 6. Security 11 Control of Security Secur	7. Age	(In yrs. last birthe	Mont	der 1 Year hs Days	If Under 24 Hr Hours Mir		gth Year) 9. Birth Cou	place (State or Foreign Intry) Land
2-0030 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show valical Expringr must be natified at	Director	10a. State 10b. County Maryland Washingt		10c. City, Town of Hagers	town	Zip Code			10g. Citizen of What Cou	10d. Inside City Limits 12⊈ Yes 2 ☐ No
er death with	items 23a o	Funeral D	16 Berner Avenue	12. Was Decedent Ev Armed Forces?		13. Was De		21740 spanic Origin? (n, Mexican, Pue	Specify Yes or No	U.S.A.	ican Indian,
ad within 72 hours after	natural', or ical Exami	by	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed		16a. D	ecedent's L	s 21 No	tion		Specify: W	hite
d within	event, Ire Med	Completed	(Specify only highest grad Elementary/Secondary (0·12) 0-11 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	olumbe	r	uring most of w		self emplo	yed
		To Be		rman Moore		Mailing Addr			Devona 1	, Maiden Sumame) Ellen Small er, City or Town, State, Zi	p Code)
9 2 6	nm 27 her tr		Betty Lou Moore - 20a. Method of Disposition 1 ☼ Burial 2 □ Cremation 3 □		20b. Place of D	Berne	er Avei	nue, Hag			21740
permit. Pages 1 a	Important: any njury		21. Signature of Funeral Service Licens)	Cedar	22. Na <i>m</i> e	and Address	of Facility		Hagerstown, Funeral Hogerstown, Ma	me
Exa	edical aminer	Examiner	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only compared the composition of the c	a. Due to (o) as a Cue to (or as a Chris	to cell consequence of V/hos/k consequence of	ular s Worć	COV	ahe m			Approximate Interval Between Onset and Death YC a.s.
that the death certificate be executed	ned by the attending physician and detached for use as the burial-transit	Physician/Medical E	IF FEMALE:	d	pregnancy		c pregnancy (specify)			23d. Date of deliv Month	ery Day Year
	been signed l should be det	by	Part II. Other significant conditions co	ntributing to death but	not resulting in th	ne underlyin	g cause giver	n in Part I.		obacco use contribute to t Yes 2□No 3□Pro	1
The	page 2	Completed							24a. Was autor perfo 1 ☐ Yes	prior to co death?	opsy findings available ompletion of cause of
l or Attanding Physician: after death.	this rat di	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Datural 5 Pending investigation	Hospital: 1	2 □ ER/Outpa 28b. Tim Year) lnju	ne of	DOA Other	4 ☐ Nursing		one dence 6 Other (Special Control Con	fy)
pital or Atta	ira O u	i Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	(Specify)				City or To		
To the Hospital	To tha Fun completely f	Medical	one)	Iner: On the basis of e	xamination and/o id.	or investigat	on, in my opi	nion, death occ	urred at the time,	cause(s) and manner as s date and place, and due t 29d. Date signed (Month,	o the cause(s)
			30. Name and address of person who c	T3 VIII)	ath (Item 23a) (To	roe, Print)	200	6222	BNIDO	3/27/4	
5H-2	Sta Registra	te	30. Name and address of person who can be seen that the seen of th	ODG 32. Registrar	HAG (South	WIN,	M9 2	1747	* · · · · · · · · · · · · · · · · · · ·	

				For State Registrar	State o	f Marylar	•		of Health of Deatl		ental Hy	giene	The state of the s	0805
		Physici		Decedent's Name (First, Manual Laura		e MOSE	ER				2. Date of De Month	Day	Year 2006	3. Time of Death
		/Medio		4a. Facility Name (If not institu Coffman Nurs:		mber)			own, or Location		,,,,,,	4c. Count	y ol Death	n
		Funeral Director		5. Social Security Number 214-09-2182	6. Sex 1 ☐ M 2 ☑ F		last birthday) 6 Yrs.	If Under 1	Year II Unde Days Hours	er 24 Hrs. Min.	8. Date of Bi (Month, D. Sept.	rth ay. Υθας) 17, 1919	9. Birthp Coun Mary	lace (State or Foreign try) Land
		show		Usual Residence of Decedent 10a. State 10b. Cou	nty		ity, Town or Lo						1	0d. Inside City Limits
		h the Marylar r 28a-f show	Director	Maryland Wasl	nington	На	gersto	Wn	ode			10g. Citizen of	What Cour	1 ☐ Yes 2XCXNo
		23a or	al Dir	17625 Heister	rboro Road			701. Zip C	21740)		U.S.		uy:
bsel	5-0036	urs after dea al', or Items Examiner ma	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M 3 ☑ Widowed 4 ☐ Divor	Armed For Married 1 ☐ Yes	2 [X]No ve		Was Deceder f Yes, specify 1 ☐ Yes 22	nt ol Hispanic C Cuban, Mexic No Specif		cify Yes or N Rican, etc.)		ce - Americ ack, White, fy: whi	etc.
2	21215-0	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23e or 28e-f show ther, the Madikal Examinar must be notified at	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1 0-12	dent's Education phest grade completed) 2) College (1-4or 5+)	(Give life. I	dent's Usual (kind of work DO NOT use ecreta	done during mo retired)	ost of workir	ng	16b. Kind of 8		•
to		m = 0 =	Be	17. Father's Name (First, Midd	dle, Last) ence Willia	- Ct ou f						, Maiden Suma	тө)	
40	Maryland	d 2 should be in and Mental in and Mental in 7 is marked o	은	19a. Inlormant's Name/Relati		III SCOUL		ng Address (S	Street and Num			Mae Mid		
i Sh	Baltimore, Ma	of Health item 27		JoAnn Bartles 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremati 4 □ Donation 5 □ Othe	on 3 Removal from	State 20b.	1762: Place of Dispo cemetery, cren kersvi	sition (Name natory or othe	of er place)	D	, Hage ch 30, 2006	20c. Location	- City or To	land 21740 wn, State Maryland
eura	Balti	permit. Page Department of Important: If any injury of		21. Signature of Funeral Serv		,			Address of Fac	cility M	innich	Funera	1 Home	
7		Physician		23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or complications that of List only one cause on a	caused the dea							>	Approximate Interval Between Onset and Death
eian -	8760,	Medical Examiner bhysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to Due to d.	(or as a conse	quence of); quence of); quence of); quence of);	Hum es leg m.	nhous nSA	rula	left l	wein	on .	2 moueles 2 moueles
ishyc	.O. Box 6	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	tcome of pregr birth 2 ☐ Fet nant at time of lown	aldeath 3□	Ectopic preg Other (spec					ate ol delive lonth	ory Day Year
P / T	ds, P	uires that i signed b Id be deta	þ	Part II. Other significant con	ditions contributing to d	leath but not re	sulting in the u	nderlying cau	se given in Par	rt I.		tobacco use co		ne cause of death?
1 umol	I Records,	: The law requir cate has been si page 2 should	Completed	DIAN	ets well	25					24a. Was auto perf 1 🗆 Yes		Were auto prior to co death? 1 ☐ Yes	psy lindings available inpletion of cause of
200	Vita	Physician: The this certificate ral director, pag	o Be	25. Was case referred to med examiner? 1 ☐ Yes 2 ☐ No	Hospital	Inpatient 2	∃ER/Outpatier	nt 3□ DOA	Other	_	Check only	onel	than (Crossif	4)
re K	on of	ng fter ine	-	27. Manne ar Leath 1 ■ Astural 5 □ Pe	28a. Date		28b. Time of Injury		: Injury at Work? 1 ☐ Yes 2[2		how injury occu		<i>,</i> ,
Nan	Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Co	uld not be ermined 28e. Place build	of Injury - At I ing, etc. (Spec	nome, larm, str	eet, lactory, o	office	2	28f. Location City or To	(Street and Nun wn, State)	nber or Rura	l Route Number,
		Hospita 24 hours Funera Intely fille	Medical C	29a. Certifier 1 Cert. (Check only 2 Medi	ifying Physician: To the cal Examiner: On the band man	e best of my kn pasis of examin iner stated.	owledge, death ation and/or in	n occurred at vestigation, in	the time, date n my opinion, d	and place, a death occurre	and due to the	cause(s) and n date and place	nanner as s , and due to	lated. the cause(s)
4		To th withir To th comp	Me	29b. Signature and title of cer	l Class	MA		29c. I	3 lala 4	or		29d. Date sign		
	, ,	11 -	9	30. Name and address of per	son who completed caus	se of death (Ite	om 23a) (Type,	Print)	CI.	1		larel nI	J1,	7//0
	8	H-2_	ate	31. Date filed (Month, Day, Y	ear) 32. F	234 C	HATTE	tamo	Jr, 17	iager.	STOWI	7/11	$1 \propto 1$	140
		Regist		MAR	28 2006	Fara	H. 1	Cartes)						

Registrar

			1 - For State Registrar	State of M	/larylar		artmen rtificat				lental Hy	giene Reg. No.	106	10807
	Physic	ian	Decedent's Name (First, Middle, La. Lester Jerry	Mason							2. Date of De Month March		2006	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give		ar)		4h City	Town or	Location of	of Death	Mai Cii	_	ounty of Deat	11:45 PM
4	CXAINII	iei	193 North Hall		,				sburg			40.0		hington
	Funeral		Social Security Number 6. S	ex 7. /	Age (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi	rth	0 Rid	hplace (State or Foreign
	Director		214 09 9021	∆ M 2□F	91	Yrs.	Months	Days	Hours	Min,	Oct. 10	, 1914	M	ary land
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	Manyli f sho	ō		natan				h						1 🕱 Yes 2 🗆 No
	28a	Director	Maryland Washi 10e. Street and Number	ngron			harps 10f. Zip					10g. Citize	n of What Co	
	h with		193 North Hall	Street					782			3	USA	
	deat	Funerai	11. Marital Status	12 Was Deceder	nt Ever in U	l.S. 13.	Was Deced			gin? (Sp	ecify Yes or No Rican, etc.)	0- 14	Race · Ame	
98	or its		1 Never Married 2XXMarried	Armed Force	Š.X.o	-	1 ⊡ Yes		Specify:	i, Puerto	Rican, etc.)		Black, White	e, etc.
8	72 hours after death with the Maryland "naturel", or items 23a or 28a-f show calcel Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates	i:	,								White
15	C 2 30	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Dece	dent's Usua kind of wor DO NOT us	rk done d	urina mos	t of work	ing	16b. Kind	of Business/	Industry
212	I within jiene.	omo	Elementary/Secondary (0-12)	College (1-4o	r 5+)		achin		,			Airc	raft Ma	anufacturer
ğ	e fillec I Hyg othe	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	e (First, Middle			
/lar	should be ind Mental marked (umatic ev	To E	William Henry	Mason					Sara	ah /	Ann Ki	dwill	er	
Maryland 21215-0036	and and ls m		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Address	(Street a	nd Numbe	r or Aura	il Route Numb	er, City or 1	own, State, Z	Tip Code)
2,	l and lealth		Anna M. Mason - W	ife	1001 0				1 Str		Sharp			
ore	Pages 1 au nent of Hea int: If Item iry or othe		20a. Method of Disposition ✓ Burial 2 ☐ Cremation 3 ☐	Removal from Stat		Place of Dispo cemetery, crer	sition (Nan natory or o	ne of ther place	9)		Date	20c. Loca	tion - City or	Fown, State
Baltimore,	t. Pa rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)								Sharp	sburg,N	Maryland
Ba	permit. Pages Department of I Important: If its eny injury or o		21. Signature of Funeral Service Licen								e,P.A.	Llion		VD 21705
			23a. Part 1. Enter the disease, or comp	olications that caus	ed the deat								sport,	MD 21795 Approximate
	Physician		fmmediate Cause (Final	one cause on each	line.				,		_	4		Interval Between Onset and Death
45,	/Medical		disease or condition resulting in death)	a. Anolus	is a conseq	uence of):	my	ocar	bull	in	forela	0		minute
86	Examiner		Conventially fire and diving	h		•	V			V				
	ם ב	iner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseq	uence of):								
	and -trans	Examiner	that initiated events resulting in death) Last	C. Dug to /or e										
8760,	cate be executed physicien and the burial-transit	a		Due to (or a	is a conseq	derice or):								
687	ficate phys s the	edical	<u> </u>	d										
Вох	leath certific attending p	by Physician/Me	fF FEMALE: 23b. Was decedent pregnant	23c, If yes, outcom								230	d. Date of defin	VALV
Ď.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant			Ectopic pro Other <i>(sp</i> e						Month	Day Year
P.O.	that the de ned by the a detached f	hys	9 Unknown	9□ Unknown										
	es thi igned be de	by F	Part II. Other significant conditions of	ontnbuting to death	but not resi	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did t	obacco use	contribute to	the cause of death?
ord	een s	Completed	hyperlepskeri,	arganie	lua	un a	ynd	ran	-		1 🗆	Yes 2 🗆 I	No 3 Pro	bably 4 Unknown
Sec	e 2 sł	nple		0							24a. Was	DSV	prior to c	opsy findings available ompletion of cause of
E E	: The	ပိ									1 Yes	rmed?	death?	2□ No
Ž	sicier certif rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only	one)		
Division of Vital Records,	Phys rald	: To	1 Yes 2 No 27. Manner of Death	1 🔲 Inpa		ER/Outpatien 28b. Time of			4 🔲 1907	sing Hor	ne 5 Resi		Other (Spec	ity)
on	ding th. : Afte	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, D	ay Year)	Injury	м	8c. Injury Work 1 🗆 Y	?` es 2 □ N			now injury o	CCUITEG	
Vis	Attendi or death ector: A by the fu	iffice	3 Suicide 6 Could not be determined	28e. Place of I	njury - At ho	ome, farm, stre	et, factory	, office		- 2	28f. Location (Street and N	lumber or Rui	ral Route Number,
	tel or A	Certification:	4 [] Hornicide	building, e	etc. (Specify	Y)					City or To	wn, State)		
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 42 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physical Example 29a. Certifier 2 Medical Example 29a.	iner: On the basis	or examina	wledge, death tion and/or inv	occurred a	at the time in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) an	d manner as	stated. to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner s	nated.			License					igned (Month	
)	⊢ <i>s</i> ⊢ ō		> Alfred					325				3/27		
			30. Name and address of person who d	completed cause of	death (ftern	23a) (Type		5 & 5	16			0/2/	106	
01	4-5		Dr. Robert Guede			Drive		edys	ville	,MD	21756	301-	-432-22	222
	Sta		31. Date filed (Month, Day, Year)	32. Regis	trar's Signa									
	Registr	ar	MAR 28 00	06 1		A A	1/2							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Francis Lawrence Mulcahey, Jr. 343A M March 25,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F 70 Director 036-24-2956 16 1935 Rhode Island Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes XX No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 13510 Spring Hill Drive 21742 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No 2/26/58 If Yes, Give Year or Dates: 2/29/88 hours after 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: White 2 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer United States Army 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: if item 27 is marked oth any liury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Be Francis L. Mulcahey, Sr. Doris Labossonniere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loretta May Mulcahey (wife) 13510 Spring Hill Drive Hagerstown Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arlington Nat'l Cem. 3-30-3006 Arlington Virginia 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiorespiratory failure **Physician** /Medical Examiner Malignancy Social stally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o s a conseq - ce of) Examine ettending physicien and for use es the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 iclan/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. the Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ End stage renal disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown brain dystunction 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No Cou 1 ☐ Yes 2 ☐ No Division of Vital To the Hospitei or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 2 ER/Outpatient 3 DOA his After this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury death. 1 Tes 2 No 2 Accident investigation after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel C 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cauca(e) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Machan Hubby, mo D62562 March 25 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHAVI HUBBLY MARYCAND 5H9+1 WASHINGTON COUNTY 251 EAST ANTIETAM STREET HAGEKSTOWN HOSPITAL 21740 31. Date filed (Mon A A Year) 32. Begistrar's Signature State Registrar

			1 - For State Registrar	State of Mary		artment of F			4000	10809
			Decedent's Name (First, Middle	, Last)		ranouto or		2. Date of Death	g. No.	3. Time of Death
	Physic		Robert Geo	rge Miksche				March 26	2006 Year	1:13 P M
	/Medi Examii		4a. Facility Name (If not institution	give street and number)		4b. City, Town, o	or Location of Death		4c. County of Death	
		4	Charlotte Hal	l Veterans Hom	ne .	Charlot	te Hall		St. Mary	, † c
	Funeral		5. Social Security Number	6. Sex 7. Age (Ir	n yrs. last birthday,			8. Date of Birth June 10,	9. Birth	place (State or Foreign
	Director		472-20-0791	1 □ XM 2 □ F	86 Yrs.			June 10,	1919 Mini	nësota
	and wo		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Many 	ģ	Maryland St. M.	arv's	Char	lotte Ha	11			1 ☐ Yes 2 ☑ No
	r 28e	Director	10e. Street and Number		- Ondi	10f. Zip Code		10	g. Citizen of What Cou	
	th wit		29449 Charlot	te Hall Rd.		20622	2		USA	
	hours after death with the Maryland turel, or Iteme 23a or 28a-1 show all Example must be collised at	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
36	or It	by F.	1 Never Married 2 Marri		1	1 □ Yes 2 No		Tiloan, etc./	Black, White	White
21215-0036	72 hours 'naturel', disal Exa	d b	3 Widowed 4 □ Divorced	Year or Dates:		7.5			Specily.	
1 5	72 8 m	Completed	15. Decedent (Specify only highes		16a. Dece (Give	dent's Usual Occup kind of work done	pation during most of work d)	ing	6b. Kind of Business/lo	ndustry
212	within liene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		okkeeper	5 /		Accountin	Q
	filed I Hygid other	0	17. Father's Name (First, Middle, L	ast)			18. Mother's Name	e (First, Middle, Mi		0
<u>la</u>	Mental Mental arked c	To B	Anthony Mik	sche			Clara Bi	raun		
Maryland	and Man		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Number,	City or Town, State, Zi	ip Code)
	and and a salth n 27		Jerome Miksche	e/Brother_	130 L	isa Drive	e., Winche	ester, VA	22603	
ore	ges 1 an t of Heali if Item 2 or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 D Bomount from State	Ob. Place of Dispo cemetery, crei	sition (Name of matory or other place	(00)	March 20	oc. Location - City or T	own, State
Ë	2 5 5 7		4 □ Donation 5 □ Other (Sp	ecity)			Crematory	28. 200	n	e Hall, MD
Baltimore,	permit. I Departm Importar any Inju		21. Signatule of Funeral Service L	icensee	22	2. Name and Addre	ss of Facility Bri	insfield-	Echols F.H	I., P.A.,
	40 E 4 0		400/15	M0000	641 30)195 Thre	e_Notch R	d., Char	lotte Hall	, MD 20622
П			23a, Part1. Enter the disease, or shock, or heart failure. List of	omplications that caused the only one cause on each line.	death. Do not ent	er the mode of dyin	ig, such as cardiac o	or respiratory arres	ŧ,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a. Ventri	cular	Avr	ythmi	a,		Onset and Death
	Examiner		,	Due to (or as a co	nsequence of):		J			
		PE	Sequentially list conditions, if any leading to immediate	Due to (or as a co	nsequence of):	umor				
	d ansit	Examiner	Signaturally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ischen	nic n	2-1-		-01		
ć	n and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):	reiu	тчор	arnez_		
8760,	icate be executed physicien and the burial-transit	dicai		, Anen	nia		V			
9	tifical ng ph as th	fedi								
Вох	death certifi e attending id for use as	A/VE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		Ectopic pregnancy			23d. Date of deliv	өгу
	the att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time		Other (specify)			Month	Day Year
<u>Ф</u>	± 20 €	Physician/Me	9 Unknown							
Š,	res tha signed t be del	by	Part II. Other significant condition	s contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.		cco use contribute to t	
5	w requir been s should	eted	Bement					1 L Yes	2 No 3 Prot	pably 4 Unknown
Record	alaw hast	Completed	D12 46	eciency	<u> </u>			24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
			Abdominal	Hortic ~	anou!	usm		performe 1 ☐ Yes 2	d? death? No 1 ☐ Yes	2 □ No
Vital	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:		13	26. Place of Death			
ō	Phys r this ral di	. To	1 Yes 2 No	1 Inpatient 28a. Date of Injury	2 ER/Outpatien 28b. Time of		A Nursing Hor		ce 6 □Other (Specif	(y)
on	ding Ph th: After thi funeral	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Yea	ar) Injury	Work	Yes 2 No	28d. Describe how	injury occurred	
Division of	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could no	ot be	At home, farm, str			28f. Location (Stree	et and Number or Rura	al Route Number
á	s efter	Certification:	4 Homicide determin	building, etc. (S)	pecify)			City or Town,	State)	ar riodio realizor,
	To the Hospital or Attenwithin 24 hours effor deati To the Funeral Director: completely filled in by the		29a. Certifier 1. Certifying (Check only 2 Medical F	Physician: To the best of my	knowledge, death	occurred at the tim	né, data and plane, s	and due to the cau	so(a) and manner as s	tated.
	in 24 in 24 in E	edical	one)	xaminer: On the basis of examiner and manner stated.	mination and/or inv	estigation, in my of	oinion, death occurre	ed at the time, date	and place, and due to	o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	01		29c. License			. Date signed (Month,	Day, Year)
•			Janul 1	Sauen.		24	5092	3	126/2	006
			30. Name and address of person w	o mpteted cause of death	(Item 23a) (Type,	Print)	5092 nce Fr	,	1.5	20678
			110 MOSpital	e 17c. Ju	ite 20	5 Pri	nce tv	edrich	MD	20678
	Sta	_	31. Date filed (Month, Day Year)	9 2006 Registrar's S	Signature	· 20 .			l	

ALICENT SCHWEIKHARD MILLER

020 eli	59 ne McN	ama	Please ra	Type or Prin								
			1 - For State Registrar	State of Ma	aryland /	Certifica			mental Hy	-	20108	10811
			Decedent's Name (First, Middle, L.)	ast)		Continue	10 01	Doutin	2. Date of De			3. Time of Death
	Physic /Med		Madeline Ric	hardson M	cNamara				March		ay Year 2006	2.22 A N
	Exami		4a. Facility Name (If not institution, g	ive street and number)		4b. Cit	y, Town, o	r Location of Deat			c. County of Dea	th
			Dorchester Ge 5. Social Security Number 6.				Cambr:		0.0-40		Dorchest	
	Funeral Director		218-24-4108	1 M 2 ⊠ F	je (In yrs. last bi 93	Yrs. Month		Hours Min.	8. Date of Bi (Month, Date) July 1	ay, Year	7) Co	thplace (State or Foreig puntry) uryland
	73		Usual Residence of Decedent						Dury	۷,	I DIZ Ma	iryranu
	h the Maryland or 28a-f ehow	,	10a. State 10b. County		10c. City, Tov	wn or Location						10d. Inside City Limits
N	the M	ecto	MD Dorch 10e. Street and Number	ester	<u></u>			bridge				1 X Yes 2 □ No
Y	with t	ä	802 Travers St.	Ant 4		10f. 2	Zip Code	21613		10g. C	itizen of What Co USA	ountry?
3	ges 1 and 2 should be filed within 72 hours after death with to Health and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or or other traumatic event, the Medical Examiner must be	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dec	edent of H		pecify Yes or N	n-	14. Race - Ame	nican Indian
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 If Yes, Give	No			lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		Black, Whit	e, etc.
21215-0036	hours after tural', or Ite al Examina	d by	3 ⊠Widowed 4 □ Divorced	Year or Dates:		1 Yes	2 🗷 No	Specify:			Specify: Wh	ite
5	י 72 hours "natural", edical Exe	Completed	15. Decedent's I (Specify only highest g		16a	a. Decedent's Us (Give kind of v life. DO NOT	vork done	during most of war	rking	16b.	Kind of Business	Industry
12	within ene. then "	d L	Elementary/Secondary (0-12)	College (1-4or 5	5+)		_				6	
	i filed I Hygi other	Be Co	17. Father's Name (First, Middle, Las	it)		Home	maker	18. Mother's Nar	ne (First, Middle	, Maide	OWN Ho	ome
Maryland	should be filed withir nd Mental Hygiene. marked other then imatic event, the M	To B	Levin Richard	son				Bessi	ie Hasse	ett		
lary	2 sho and N Is ma		19a. Informant's Name/Relationship	(Type, Print)	191	b. Mailing Addre	ss (Street	and Number or Ru	ıral Route Numb	er, City	or Town, State, 2	Zip Code)
	of Health Itom 27		Donald R. Creig	hton so				Dr., Can		MD	21613	
Baltimore,	ges 1 t of H If ite		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3	☐Removal from State	20b. Place of cemete	of Disposition (N ery, crematory or	iame of r other plac	xe)	Date	20c. l	_ocation - City or	Town, State
Ë	rtmen rtant: nlury		4 Donation 5 Other (Spec		Old Ti	rinity (/27/06		urch Cre	
Bal	permit. Pages 1 Department of H Important: If ite eny Injury or ott		21. Signature of Funeral Services hick	ensee				ss of Facility 7			ral Home 21613	P.A.
			23a. Part 1/Enter the disease, or con	mplications that caused	the death. Do					•	21013	Approximate
	Dhysisian		Immediate Cause (Final	y one cause on each iii	ne.	,			or respiratory a	irest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	a consequence	Inha	lat.	<u> </u>				
	Examiner		Constitution for the second	L 200 to (0. 00	a 001100q001100	. 517.						
	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	of):						
	executed en and irial-translt	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
60,			Toolston g in doubly East	Due to (or as	a consequence	of):						
6876	The law requires thet the death certificate be exate has been signed by the ettending physicien bage 2 should be detached for use as the burial	Physician/Medica	•	d								
Box (certif nding use e	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of del	ivon
	death e ette d for	iciai	in the past 12 months?	1□Live birth 4⊡Pregnant at		n 3 □Ectopic 5 □ Other (s		<u> </u>			Month Month	Day Year
P.0	of the by the tache	hys	9 Unknown	9□ Unknown								
	w requires thet been signed to should be deta	ρ	Part II. Other significant conditions	contributing to death b	ut not resulting i	in the underlying	cause give	en in Part I.	23e. Did 1	obacco	use contribute to	the cause of death?
ord	equir een s	ted							1 🗆	Yes 2	2 0 No 3 □ Pr	obably 4 Unknown
Records,	a taw nasb	Completed							24a. Was		24b. Were au	topsy findings available
E	The taw cate has	S							perfo 1 ☐ Yes	rmed?	death?	2□ No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Dea				
ō	Phys rthis raldii	. To	1X Yes 2 No 27. Manner of Death	1 Inpatie	-	utpatient 3		4 U Nursing H	ome 5 Resi		6 Other (Spec	cify)
Division	Attending in death.	tion	1 □Natural 5 □ Pending 2 ☑ Accident investigation	(Month, Da)	y Year)	Injury	28c. Injun Worl	k? Yes 2 X No			house	Fire
VİSİ	Attendir death.	Ifica	3 Suicide 6 Could not	28e. Place of Inju	ury - At home, fa				28f. Location /	Street a	nd Number or Ru	ral Boute Number
Ö	s ette	Certification:	4 Homicide determined	building, etc	c. (Specify) A	t ho	na 0		#4. Car	wn, Stat	(e) 807 T	ravers st.
	hour hour unera	cai (29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge	e, death occurre	d at the tin	ne, date and place	and due to the	cause(s	s) and manner as	stated.
	To the Hospitel or Attending Ph within 24 hours elter death. To the Funeral Director: After th completely filled in by the funeral	Medicai	0.107	miner: On the basis of and manner sta	ated.				ned at the time,			
	Vill To	~	29b. Signature and title of certifier			2	9c. License	e number		29d. Da	ate signed (Monti	h, Day, Year)
			m m	mis			OCME			Mar	ch 24, 2	2006
			30. Name and address of person who	completed cause of d	eath (Item 23a)		1 D	- C+ ·	D. 7. '		М. 7	_ 1 01 0 O 1
	St	ate	31. Date filed (Month, Day, Year)	32 Paristra	ar's Signature	11	r Per	n Street	Baltim	ore,	Marylai	na ZIZUI
	Regist		MAR 27	2006	w K	Losal						

			For State Registrer	State of	Marylan		artment tificate			nd Me	ental Hyg	giene leg. No.		0812	
	Physicia	ın	1. Decedent's Name (First, Middle, Last Arliene W. McEl							2	2. Date of Dea Month	Day Y	ear	3. Time of Death	
	/Medic Examine	al	4a. Facility Name (If not institution, give Chesapeake Woods	street and num	ber)		4b. City, 1		Location of D		March	4c. County of	Death	6:30 p ™ mester	-
,	Funeral Director		5. Social Security Number 6. S 040-14-0514		. Age (In yrs. 1	last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8	B. Date of Birth (Month, Day March 1	5, 1920 s	Birthpla Countr Ma	ace (State or Foreign 1) 11110	7
all	be filed within 72 hours after death with the Maryland stal Hygiene. Idea (1998) and the Markel, or Items 23a or 28e-1 show event, the Markel Examilier is used by mailfied at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Dorches 10e. Street and Number	ster	10c. City	y, Town or Lo		Code	w Mark	ket	1	Og. Citizen of Wh		d. Inside City Limits 1 ☐ Yes 2 ☑ No	_
Sign	23a	Ia I	3349 Ocean Gatewa	y					1631				USA		
980	ours after de rel', or Items Examiner	<u>چ</u>	11. Marital Status 1 □ Never Married 2 □ Married 3 ☞ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es?		Was Decede fYes, speci I∐Yes 2		spanic Origin n, Mexican, F Specify:	n? (Sp <i>ec</i> : Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Black, Specify:	American White, et	tc.	
Baltimore, Maryland 21215-0036	within 72 he ene. than "natu ne Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4	4or 5+)	life. L	kind of worl OO NOT use	k done d e retired,	luring most of		7	16b. Kind of Busin			
2	filed withl Hygiene. other than ent, ine M	S	12 17. Father's Name (First, Middle, Last)			Self	Emplo	yed	Beauti			Hair & C	osme	tic	_
ylan	should be and Mental s marked o urnatic eve	To Be	Maurice McGary			T			Nac	lelle	e McGar	y Dimick			_
, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		19a. Informant's Name/Relationship (1 Cheryl A. Jervis,			4707	King .	John	Way,	Uppe	er Marl	, City or Town, Sta boro, MD		0772	
more	Pages 1 nent of Ho int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			lace of Disposemetery, crem ShoreC	remat	ionC	enter	3/22	2/2006	20c. Location - Cit Cambride	. M		
Balti	permit. DepartmImporta any inju		Eleignature of Funeral Service Licen		Muse	22 CS	Name and	Addres Brogh	s of Facility Twell Ca	Fune	eral Ho	me, 21613	, -,		_
8760,	te be ysicia ne bui	dicai Examiner	23a: Part1. Enter the disease or compensors, or heart sature. List only in Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	r as a consequence as a	uence of):	nce	, .	, such as ca	Turac or 1	өэрласогу алг	esi.	l li	Approximate niterval Between Onset and Death	_
.O. Box 6	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal nt at time of de	death 3 🗆	Ectopic pre Other (spe				_	23d. Date of Month	,	r Pay Year	
rds, P	w requires that the debeen signed by the should be detached		Part II. Other significent conditions on Emphesema, Hy,	ontributing to dea	th but not resultence	ulting in the un	aderlying ca	ase give	n in Part I.	_	23e. Did tob	pacco use contribu es 2 □ No 3[cause of death?	
Division of Vital Records, P.O	: The law re cate has be- r, page 2 sho	Completed by	Osteoarthritis, F	nsion t	Insi	yroid iffici	, Osto	eope	nosus		24a. Was an autops perform	n 24b. Wei ry prio ned? dea 2 No 1	re autops r to comp th? Yes 2	y findings available pletion of cause of No	
Ş	s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🕱 No	Hospital:	patient 2 1	EP/Outpations		0.1			Check only on		(Ci4.)		_
ion of		ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		28b. Time of Injury		c. Injury Work	dt Nursir at ? es 2 □ No	28		ence 6 Other (Specity)		_
Divis	tel or Atters as after deiter deiter dei by the ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place o	f Injury - At ho g, etc. <i>(Specify</i>	me, farm, stre	eet, factory,	office		28	f. Location (Sti City or Town	reet and Number on, State)	or Rural F	Route Number,	_
	To the Hospitel within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Physical Exemption	sicien: To the b iner: On the bas and manne	is of examinat	wledge, death ion and/or inv	occurred at estigation, i	t the time in my op	e, date and p inion, death o	olace, and	d due to the ca at the time, da	ause(s) and manne ate and place, and	er as state due to the	ed. ne cause(s)	
	To t To t	2	29b. Signature and title of certifier	r of	K	120	29c.	License 44	number 4615		29	9d. Date signed (A $3/21/$	100th, Da	ay, Year)	
			30. Name and address of person who d	ompleted cause	100	Bran	11	5-	tree	+ (Canb	ridge,	MI	21613	_
	Stat Registra	-	31. Date fled (Month, Day, Year) 2 3	2006 ^{32. Red}	krar's Signat	ure	Coul	2				•			

Box 68760 of Vital Records, P.O.

MacDanald, Agnas

Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 0710 M 21 2006 AGNES MELLON MACDONALD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital at Easton Easton Taibot If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 ₩ F 577-26-7300 83 Yrs Director DEC 18, 1922 WASHINGTON DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show CAROLINE RIDGELY 1 XYes 2 ☐ No Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21660 202 PARK AVE. USA Funerai or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? other treumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ltimore, Maryland 21215-0036 ۵ 1 ☐ Yes 🌠 No Specify: 3X Widowed 4 □ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry DRAPERY then " Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING O SEAMSTRESS 12 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F CHARLES LEO MELLON LORAINE AGNES RYON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Heelth a Important: If Item 27 is any lojury or other treu once. LORAINE STOUTSENBERGER/DAUGHTER PO BOX 532, 202 PARK AVE., RIDGELY, MD 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR. 3/22/2006 STEVENSVILLE, MD 21. Signature of Funeral Service Line FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to for as a consequence of): /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physicien and for use as the burial-transit The law requires that the death certificate be executed rementra Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 Yes 2 No 1 Tyes 2 No Director: After this certific I in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or pelli within 24 hours a 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely one) To the 29b. Signature/and title of certifier 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 24 2006

Registrar

9

2006

			1 - For State Ragistrar	State of Marylar			nt of He te of D		nd Me		giene	06	10815
;	Physici /Medic Examin	cal	Decedent's Name (First, Middle, Last, Janet Engli 4a. Facility Name (If not institution, give	sh McJilt	on	4b. City	, Town, or l	ocation of	n	Date of Dea Month	Day .	Year	
	Funeral Director		217-20-4271	MUM 28 F 74	INTU/ . last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 2	4 Hys. 8. Min.	Date of Birt	h 32	9. Birth New	place (State or Foreign ntry) Jersey
	death with the Maryland me 23a or 28a-f show roust be notified at	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Wicomic		ity, Town or Lo	ury	_						10d. Inside City Limits X□ Yes 2 □ No
	leath with ti	Funeral Dire	10e. Street and Number 227 W. College	Ave.	J.S. 13 1		ip Code 21801	nanic Origi	in? (Specif	y Yes or No	10g. Citizen d USA		
0000		þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		If Yes, sp	ecify Cuban	, Mexican,	Puerto Rio	an, etc.)		llack, White,	
-61717	withir ene. then	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	(Give	kind of w DO NOT	ual Occupat ork done du use retired) nt Mar	iring most o	of working		16b. Kind of	Business/Ir	,
rytand	2 should be filed end Mental Hygi is marked other sumatic event, I	To Be	17. Father's Name (First, Middle, Last) James Hilton Engl 19a. Informant's Name/Relationship (Ty		10- 14-7			Ali	ce Ma	ude Kl			
re, ma	and and m 27 m 27 her tr		Janet P. McJilton 20a. Method of Disposition	/daughter	227 Place of Dispo	W.	Colleg	ge Ave	e., S	alisbu	or, City or Tow Iry, MI 20c. Locatio	2180	1
Saltimo	permit. Pages 1 Dapartment of H important: If ite any injury or ot once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	Sa Sa	lisbury	/ Cre	emator	у 3	3/24/0 al Ho			sbury.	, MD ssociation
9700,	Certificate be executed Certificate be executed by executed Certificate be executed by	dicai Examiner	23a. Part1. Enter the disease, or comples shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reaumg to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	th. Do not ent Companies Companies Companies Quantice Oil.	er the mo		, such as c					Approximate Interval Between Onset and Death
O. Box og	tha death certif y the attending iched for use a:	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 6	aideath 3 ☐	Ectopic Other (oregnancy specify)					Date of deliving the delivers of the delivers	ery Day Year
cords, P.	w requires that tha de. been signed by the a should be detached t	þ	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying	cause giver	n in Part I,			obacco use co es 2 🗹 No		he cause of death?
Vital Rec	The law ate hes b page 2 si	e Completed	25. Was case referred to medical							1 ☐ Yes	rmed? 2 D No	prior to co death?	opsy findings available impletion of cause of
5	ding Phys	To B	examiner?	lospital: 1 Inpatient 2 Inpati	ER/Outpatier 28b. Time of Injury		OA Other 28c. Injury : Work?	4 ☐ Nurs	sing Home		ne) lence 6 🗆 0 low injury occ		(y)
DIVISION	To the Hospital or Attent within 24 hours attar death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ify)					City or Tow	m, State)		al Route Number,
	thin 24 ho the Fun mpletely i	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin- and manner stated.	ation and/or in	vestigatio	n, in my opi	nion, death	place, and occurred	at the time, o	date and plac	e, and due t	o the cause(s)
)	(B)		> runch				Do 573			1	March	•	
	Ste	ate.	30. Name and address of person who con the control of the control	KAN ILIT	S. MIVI	SIDM	ST	SALI	SBUR	y M	2180	4	
	Registi		MAR 2 3 20	32. Pogistrar's Sign	K A	mark	,						

DHMH 17 Rev 1/2001

LANCE MCDITTER

		For State	State of N	Marylan			f Health an	nd Mental		000	,**	10016		
		Registrar 1. Decedent's Name (First, Middle,	rtificate of Death				Reg. No. 3, Time of Death							
Physici		Mary	Monica	M	artin			Mon	th	•	Year	M		
/Medio Examin		4a. Facility Name (If not institution,				4b. City, Tow	n, or Location of D	Mar Death	cn /	9 , 200 4c. County o		11:30 P [™]		
		Memorial Hospi	tal			Cumber	cland			Allega	ny			
Funeral Director		5. Social Security Number 220-40-0832	6. Sex 1 ☐ M 2 ☐ X F	Age (In yrs. 65	last birthday) Yrs.	If Under 1 Ye Months Da		Min. B. Date	of Birth th. Day. Ye			ace (State or Foreign try)		
D .		Usual Residence of Decedent 10a. State 10b. County		10c Cib	y, Town or Lo	cation					1/	Od. Inside City Limits		
Aaryla	2	MD Alleg	any	100. 010	Cumb	erland						1 □Xes 2 □ No		
the h	Director	10e. Street and Number				10f. Zip Cod	le		10g.	Citizen of W	hat Coun	try?		
h with	i D	701 4th Street					21502			US	A			
hours after death with the Maryland turel, or flems 23s or 28s-f ehow al Examinar must be notified at	Funerai	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.	S. 13. V	Was Decedent f Yes, specify (of Hispanic Origin Cuban, Mexican, F	n? (Specify Yes Puerto Rican, e	or No-		- America			
s afte	by F.	1 Never Married 2 Marrie	od 1 Tes 2 (X No		1 ☐ Yes 2 ☐					white			
hour: turel'		3 Widowed 4 Divorced	Year or Date	·S:	16a Decer	dent's Usual Oc	cupation		161	. Kind of Bu				
be filed within 72 hc tal Hygiene. d other than "natu	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4c	or 5+)	(Give	kind of work do DO NOT use re	one during most of	l working		xtile	311033/110	usity		
be filed v ntal Hygie of other t		17. Father's Name (First, Middle, L	ast)	-	labore		18. Mother's	Name (First.)			в)			
2 should be filed within and Mental Hygiene. Is marked other than eumatic event, tra M	To Be	Gerard T. Mar					Moni	ca Inez	(Enge	elbach	Mar	tin		
as 1 and 2 should be of Heelth and Ment Iltem 27 is marked rother treumatics		19a. Informant's Name/Relationsh Veronica Valent	in (Type, Print) ine sist	er	19b Mailig	23 Cam	pbell Roa	or Rural Route ad Co	onnea	ut Lak	State, Zip. E	A 16316;		
permit. Pages 1 e Department of He Importent: If Item eny injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		St.	Place of Dispo emeters, cred Mary's C	sition (Name of patory of other emetery	f place)	Date 4/3/20		Location - C Cumbe		wn, State MD		
Departi Departi Importi eny Inj		21. Signature of Funeral Service L	d. DCa	real	22	•	lethi Pน์metra /irginia Ave			id, MD 2	21502			
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between												
Physician	Immediate Cause (Final disease or condition HVDOTENSTVE SHOCK									1	Onset and Death HOUR			
/Medical Examiner		resulting in death)					1 7							
	PE	Sequentially list conditions, if any, leading to immediate	uence of):				-	1	DAY					
uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ONEY D	CSEASE				5	YEARS					
be executed sicten end burial-transit		resulting in death) Last	uence of):											
the Section	edicai	4.	d.RIGHT A	d RIGHT ARM CELLULITIS						1 WEEF				
eath certific ettending p	ician/Me	IF FEMALE: 23b. Was decedent pregnant	ancy	Ectopic pregn				23d. Date	e of delive	ry				
Attending Physician: The law requires that the death certific rideath. actor: After this certificate has been signed by the ellending is by the funeral director, page 2 should be detached for use as	Physicia	in the past 12 prionths? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	t at time of d		Other (specif)				Mor	nth	Day Year		
res that signed t	by P	Part II. Dther significant condition	as contributing to deat	h but not res	ulting in the u	nderlying cause	given in Part I.	236	. Did tobac	co use contr	ibute to th	e cause of death?		
v require been sig	ted t	DIABETES MELLITUS, CORONARY ARTERY DISEASE, MORBID							2 No 3 Probably 4 Unknown					
law r las be s 2 sh	Completed	OBESITY			248	. Was an autopsy	24b. V	Vere autop	osy findings available inpletion of cause of					
hysician: The lar his certificete has I director, page 2	S							10	yes 20	1?] d	eath?	21XN0		
sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Other	f Death (Check	71111					
Phys oral di	. To	1 Inpatient 2 EPOUtpatient 3 DOA 4 Nursing Home 5 Hesidence												
nding th.: Afte	tior	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury 28b. Place of Injury - At home, farm, streed building, etc. (Specify)					f 28c. Injury at 28d. Descrit Work? M 1 ☐ Yes 2 ☐ No							
or Atte efter dez Director in by th	Certification:										(Street and Number or Rural Route Number, Fown, State)			
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.	edical Co	(Check only 2 Medical E	g Physician: To the be examiner: On the basi	s of examina	owledge, deat	h occurred at the	ne time, date and my opinion, death	place, and due occurred at the	to the caus	e(s) and mai	nner as st	ated. the cause(s)		
o the ithin 2 o the	Med	one) 29b. Signature and title of certifier	and manner	r stated.			cense number			Date signed				
⊢≯⊢ŏ		Valin	hat 1	Jani	ah		5815	5		411	104	5		
		30 Name and address of person v		of death (Item	n 232) (Type,	Print)				4	100			
6		Sahabat Nawa	b M.D.		∥ P. 0.	Box 26	5 Grants	ville MD	2153	ნ				
Sta Registi		31. Date filed (Month, Day, Year) APR 9 6 21	006 32. Reg	pistrar's Signa	ature	Es.						i,		

			1 - For State Registrar		State of	Marylan	•			ealth a Death	and M		Rag. Nó.	006	108	3 7	
	Physici		1. Decedent's Name (First, Midd E //en	B.	Mye	r5						2. Date of De Month March	Day	Year	رب	of Death	
	/Medio Examin		4a. Facility Name (If not institution					4b. City		Location of			4c. 0	county of Dear	6 6 2		
2014			Mennonite 5. Social Security Number	Fe 6. Sex	llowski	*	ast birthday)	If Unde	r 1 Year	If Under		8. Date of Bir	th		holace (State		
	Funeral Director		200-52-1448	1 🗆	M 201F		6 Yrs.	Months		Hours	Min.	Nov. 2	2, 19	09 PA	hplace (Stateuntry)	e or r oreign	
	and w.		Usual Residence of Decedent 10a. State 10b. Count	y		10c. Cit	ty, Town or Lo	cation							10d. Inside	City Limits	
	Maryl	tor	MD Washington Hagerstown									1 🗆 Y	es 2 MNo				
तंत्र वर्षः संस्	or 28s	Jirec	10e. Street and Number					10f. Z	p Code					en of What Co	ountry?		
	s 23a	ral l	12349 Huyet			Francis II	S 140		2174		-1-0 (0	-4 - V N -		ISA 4. Race - Ame	dana ladiaa		
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural, or items 23a or 28a-f ehow or other treumatic event, it a Musical Examinar must be profilled at	by Funeral Director	11. Marital Status 1 □ Never Married 2□ Ma 3 ☑ Widowed 4 □ Divorce	rried	2. Was Decedo Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Date	es? ☑No	-	was Dec If Yes, sp		Specify:		cify Yes or No Rican, etc.)		Black, White	e, etc.		
5	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						ng	16b. Kin	d of Business	Industry					
121	within ene. than		Flementary/Secondary (0-12) College (1-4or 5+)					omemaker					Own home				
7 9	should be filed nd Mental Hygid marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name							Paulus							
lary	2 should and N is mail		19a. Informant's Name/Relation				1	-				l Route Numb					
	Health tom 27 item 27 i		Catherine Loui 20a. Method of Disposition	se M	yers/da		100				Road	, St. T		ation - City or	.7252 Town, State		
nor	ages ant of I it: If ite y or o		1 Burial 2 Cremation 4 Donation 5 Other		moval from St	die	Place of Dispondent Commetery, creating Commetery, creating Commeters (Commeters)			e)	March	31,		ersburg			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		21. Signature of Funeral Service		Dies	1 110	22	2. Name a	ind Addres	ss of Facilit	yLin'	inger-F ercersb			1 Home 236	e Inc.	
P.O. Box 68760, nat the death certificate be executed Washing attending physicien and letached for use as the buffal-fransit	tical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Between					
	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23	23c. If yes, outcome of pregnancy 1							2	23d. Date of delivery Month Day Year				
	sign d be	Completed by Pi	Part II. Other significant conditions continuous to death but not resulting in the underlying cause given in Part I.									pacco use contribute to the cause of death? as 2 \(\sum No 3 \super \text{Probably 4} \sum \text{Unknown} \)					
Vital Records,	The law ate has b page 2 s											24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No					
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?	Heaptel:													
of	Phys er this eral di	. To	Yes 2 No 27. Manner of Death		28a. Date of Injury 28b. Time of				nt 3LI DOA 4 ANUISING HO			ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
ion	Attending I ir death. ector: After by the funer	atto	E //ooldon	tigation	(Month	, Day Year)	Year) Injury Work? M 1 ☐ Yes 2 ☐ No										
Division	5 # 5 E	Certification:									ural Route N	lumber,					
	Hospitel 24 hours a Funeral letely filled	edical			ician: To the been on the base and manner	is of examin										se(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certification	ier	2.10 1/1011116			2	9c. Licens	e number			29d. Date	signed (Mon	th, Day, Yea	r)	
			> XXX <	TEPHZ	W KOTI	A. Dr	E, MC		00	056	965	•	Mo	March 28, 2006			
	6		30. Name and address of person	n who cor	mpleted cause	-			tous	n	MO	217	40	(tooler	V+L	mo	
	and the second	ate rar	31. Date filed (Month, Day, Yea	7)	32. Re	gistrar's Sign	ature		1000	•	, ,	CK, (Oly Property	1,0010-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** aron 31, 2006 EDWARD EUGENE MYERS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 77 212-24-6528 EMMITSBURG, Director Usual Residence of Decedent death with the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 27 is marked other than "natural", or Itama 23a or 28a-f ahow traumatic avent, the Medical Examinar must be notified at 1 X Yes 2 ☐ No Director **EMMITSBURG** MD FREDERICK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21727 707 E. MAIN ST. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2/should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RADIO & TV OWNER & OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ADA **ASHBAUGH** EDWARD L. MYERS G. 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health a Important: If Itam 27 is any injury or other tra 17634 TRACT RD., EMMITSBURG, MD. 21727 PATRICIA A. ORNER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State NEW ST. JOSEPH'S 4/5/2006 EMMITSBURG, MD. 21727 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME m. EMMITSBURG, MD. 21727 210 W. MAIN ST., 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** myse Due to (or as a consequence /Medical of): **Examiner** a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day as been signed by the atte 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II_/Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificete has page 2 No Was case referred to medical 1 Yes funeral director, 25 Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Medical Certification: To 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending within 24 hours after use..... To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Year, 29b. Signature/and title of certifier ben 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue Hagerstown, MD 21742

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

Certificate of Death

2. Date of Death

Month

OB

Day

Year

06

Allegany

USA

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

Month

Specify:

14. Race - American Indian, Black, White, etc.

White

3. Time of Death

S130

10d. Inside City Limits

Approximate Interval Between Onset and Death

6 mos

Year

1 Yes 2 No

Birthplace (State or Foreign Country)

McCoole, MD

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of perso

31. Date filed Month/Day

For State Registrar

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Wayne Markle

Gerald

32 Registrar's Signature

2006

who completed cause of death (Item 23a) (Type, Print)

JOSE T. WOVERLA JR., MI) 912 SETON DRIVE CUMBITIZIAND MW 21502

	1 - For State Registrar	State of Marylan	•	rtment of tificate of		*	giene Reg. No.)	10820		
Physician	Decedent's Name (First, Middle, Last) Rosa	Lavern		Nolan		2. Date of De	ath 24, Day 2006 Yea	3. Time of Death		
/Medical	4a. Facility Name (If not institution, give				or Location of De		4c. County of De	2:35P M		
Examiner	St. Mary's Nurs			Leonar		201	St. Ma			
Funeral Director	5. Social Security Number 6. Sec 1579-64-5012		last birthday) Yrs.		If Under 24 H		th 9. F	Sirthplace (State or Foreign Country) Shington, DC		
aryland •how	Usual Residence of Decedent 10a. State 10b. County Marry Land St. Marry	_	ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
with the Mac t or 28a-f elemental lines	Maryland St. Mar	y s Ne	chanic	10f. Zip Code			10g. Citizen of What			
3a or	36907 Westlake Dri	V A		2065	i a		USA			
and 21215-0036 be filed within 72 hours after death with the Maryland nial hygiene. od other than "natural", or Iteme 23a or 28a-f show event, the Medical Examinet must be notified at Be Completed by Funeral Director		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1		Hispanic Origin? oan, Mexican, Pue	(Specify Yes or No erto Rican, etc.)		merican Indian, hite, etc. Black		
21215-003 ed within 72 hours a regione. is then "neturel", c. t. the Medical Exer	15. Decedent's Edu (Specify only highest grade	e completed)	16a. Deced	ent's Usual Occu kind of work done	pation during most of weed)	orking	16b. Kind of Busines	ss/Industry		
2121 d within giene. or then "	Elementary/Secondary (0-12)	College (1-4or 5+)			oordinat		Parks & R	ecreation		
Maryland 21215-0036 and 2 should be filed within 72 hours attemed to the remaining treatment over treatment over, the medical Event To Be Completed by F	17. Father's Name (First, Middle, Last) Billie Gri	m Saunder	's		18. Mother's N Fern	ame (First, Middle, Isabe)	Maiden Sumame) 11e Le	e		
Mary d 2 sho th and h ty 1s ma treuma	19a. Informant's Name/Relationship (Ty, Joseph A. Nolan/Sp						er, City or Town, State			
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other treumatic eonce.	20a. Method of Disposition 1 🖺 Burial 2 🗆 Cremation 3 🗆 R 4 🗆 Donation 5 🗆 Other (Specify)	20b. F	Place of Dispos cemetery, crem	sition (Name of natory or other pla	ace)	Date	20c. Location - City			
Baltir. F permit. F Department important any Injur. sonce.	21. Signature of Funeral Service License	Ehal 1	^ ²²	Name and Addd rinsfie.	of Eachity 1		Home, P./			
Physician	23a. Part 1. Enter the disease, or complications that caused to tenth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each limit. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death SCCROSIS THE CONTROL OF THE CONTROL O									
executed Examiner in and inliner Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b								
8760, ate be executed hysician and the burial-transit	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
of Vital Records, P.O. Box 68760, Physicien: The law requires that the death certificate be executed rithis certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit: To Be Completed by Physician/Medical Examir	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	ıl death 3 □	Ectopic pregnand Other (specify)	э у		23d. Date of c Month	delivery Day Year		
cords, P w requires that been signed b should be deta	Part II. Other significant conditions con	contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of deal			
Division of Vital Records, to Attending Physicien: The law requires teller death. Director: After this certificate has been signs in by the funeral director, page 2 should be ertification: To Be Completed by										
Vital Fisions The certificate rector, page	25. Was case referred to medical examiner?	Inenital:		! 0		eath Check only o	ne)			
E ga eat	27. Manner of Death 1 Death 1 Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Holl 28a. Date of Injury 28b. Time of					lome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
Division (tel or Attending F rs effer death. si Director: After ed in by the funer. Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (5 City or Tov	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Divisio To the Hospital or Attendi within 24 hours eiter death. To the Funeral Director: A completely filled in by the tr	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the t estigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)		
To the within To the complete	29b. Signature and title of certifier	K	15		se number (7096		29d. Date signed (Mo			
	30. Name and address of person who co Rajbinder Gill,	mpleted cause of death (Item	n 23a) (Type, I	Print)	land 206	36	3-21-0			
State Registrar	31. Date filed (Month, Day Year) MAR 2 9		-	_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 26 per dyr 9854 4-6-06 yt.

State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 30,2006 10120 am Virginia Mar. Nealis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland 56 Maple Street If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Apr 16, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 ☐ F ^{CO}WID Yrs. 88 Director 219-14-5655 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location •how 10d. Inside City Limits r then "naturel", or items 23e or 28a-f ehov the Medical Examinar must be notified at Cumberland MD Allegany 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 56 Maple Street USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. filed within 72 hours after I □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed by 3 K Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. important: if item 27 is marked other then "na eny injury or other treumatic event, the Media once. Elementary/Secondary (0-12) 12 Cotlege (1-4or 5+) Celanese Corp. laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martha Stevens James Stevens ၀ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 56 Maple Street Cumberland MD 21502 daughter Marilyn Wilson 20b. Place of Disposition (Name of cemetery, crematory or other place Sunset Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 Cremation 3 Removal from State 4/4/2006 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Nam Straffetti Futiteral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine.

Immediate Cause (Final disease or condition resulting in death)

a. Curous Brouchts - Eurphy Seure Approximate Interval Between Onset and Death **Physician** 5 yes /Medical Due to (or as a consequence of) Examiner Section tally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 9 3 ☐ Probably 4 ∰Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an rmed? 2 0 No 1 Yes To Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2/15 No Other: 4 Nursing Home Residence 6 Other (Specify) After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours of To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who complete

31. Date filed (Month, Day, Year)

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible lak. Ensure All Copies Are Legible. Amend 1 tem 24a per ur 854 4-6-06 vt.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 30, Day 2006 **Physician** Margaret E. O'Neill 0336 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Havre de Grace Harford Memorial Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
June 22, 1921 Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days Hours 1 □ M 2 🛣 F 213-14-3466 84 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 XXes 2 □ No Director Harford Aberdeen Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA 731 Webb Street 21001 or Iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 25000 If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes XXNo Specify: Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene int: if Itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) secretary manufacturing 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Julia Nesline Morris Shroyer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter F. O'Neill (husband) 731 Webb Street, Aberdeen, Maryland 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. ŏ R.A. Ferris & Co., Inc. 3/31/06 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 21. Signature of Euroral Service Licenses Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** onas /Medical Due to (or as a consequence of): OPIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physicien and use as the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď been signated 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2 🛣 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Epatient 1 ☐ Yes 2 ZNo ို 2 ☐ ER/Outpatient 3 ☐ DOA Sid 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural Injury 5 Pending s efter dec-al Director: Afr 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral L filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

281 E. Main

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5%.



rising

Sich,

3906

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

JAMES WOODROW POTTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 3:05 March 23, 2006 Susan Elizabeth Powell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 18,1951 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 21/7F 55 171-44-4520 Director Usual Residence of Decedent death with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 Is marked other than "natural", or itams 23a or 28a-1 shov or other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21915 Brook Drive 20619 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ifiled within 72 hours after of Hygiene.

Hygiene.

other than "natural", or ital 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Government Contractor System Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be in nent of Health and Mental I sut: If item 27 is marked o 0 Jacob Franics Herron Sara Clara Schaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21915 Brook Drive, California, Maryland 20619 William Richard Powell/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Removal from State 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Face Cemetery March 28,2006 Great Mills, Maryland 21. Signature of Funeral Service Livensee 22. Name and Address of Facility
Mattingley—Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 whall 23a. Part1. Enter the disease, ir complice nons that caused the disabshock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe CANCER Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 fF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cete hes been signed page 2 should be det Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? þ VENOV? 1 Yes 2 10 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 100 1 Yes 2 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ Certification: 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation after death Director: the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 3-23-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S · Gili SMAM ASSOCIATES MOLYWOOD MD MATRINZER 31. Date filed (Mont WAR 227) 7 32. Agistrar's Signature State 2006 Registrar

			State of Ma		d / Depa		f Health	and M	ental Hyg		06	1082	.5
		1. Decedent's Name (First, Middle, Last)							2. Date of Deal Month	h Day	Year	3. Time of D	Death
Physici /Medio		Patricia Lor	raine Pa	arker					March	22	2006	2125	M
Examir		4a. Facility Name (If not institution, give st	reet and number)			4b. City, Tov	m, or Location	of Death		4c. Co	unty of Death		
		Dorchester Genera					mbridg				Dorche		-
Funeral		5. Social Security Number 6. Sex	7.Age M.2 5 ⊈F		st birthday) Yrs.	If Under 1 Y Months Da	ear If Unders	or 24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthi	olace (State or	Foreign
Director	ļ	227–26–5903 Usual Residence of Decedent		65			1		May 19	, 1940	Mar	yland	
land ow		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City	y Limits
Mary Mary	ţo	MD Dorchest	er			C	ambrid	.ge				1 XYes	2 🔲 No
death with the Maryland ims 23a or 28a-f show	Funeral Director	10e. Street and Number				10f. Zip Co	de		1	0g. Citizer	of What Cou	ntry?	
h witi	a D	200 Meteor Ave.,	Apt. 104				2161	3			USA		
deat	ner	11. Marital Status	2. Was Decedent 8 Armed Forces?	Ever in U.S	S. 13. \	Was Decedent f Yes, specify	of Hispanic C Cuban, Mexic	Origin? (Spe an, Puerto l	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,		
or It		1 Never Married 2 Married	1 ☐ Yes 2 🗹 N If Yes, Give	10		1 ☐ Yes 2 🗷				Sp	pecify: wh	ite	
within 72 hours after ene. than "natural", or Ita	d by	3 ⅓ Widowed 4 □ Divorced	Year or Dates:		10- P	dantia Llaval O					of Business/In		
"nat	lete	15. Decedent's Educa (Specify only highest grade	ation completed)		(Give	dent's Usual O kind of work d DO NOT use re	one during m	ost of worki	ing	IOD. KIIIQ	Of Busiliess/iii	laustry	
withii ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)		rivate				el	der car	re	
be filed within 72 hours after death with the Marylan ital Hygiene. d other than "natural", or Itams 23a or 28a-f show event. It a Madical Esaminar must be rediffed at		17. Father's Name (First, Middle, Last)			L				(First, Middle,	Maiden Su	ımame)		
	To Be	Ira G. Wroten					L	ettie	Bromwe:	11			
	-	19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailir	ng Address (St	reet and Num	ber or Rura	l Route Number	City or T	own, State, Zij	Code)	
2 # 2 T		Philip Wroten	brothe						bridge,		21613		
es 1 au of Hea of Hea fitem		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	moval from State	20b. Pla	ace of Dispo metery, crer	sition (Name on matory or other	f place)	D	Date	20c. Loca	tion - City or T	own, State	
permit. Pages 1 a Department of Hez Important: If item any injury or othe		'4 □Donation 5 □Other (Specify)	movar nom otato	East		Market						rket, M	D
permit. Pages 1 Department of H Important: If ite any injury or ot ance.		21. Signature of Funeral Service License	Э			Name and A			homas Fi			P.A.	
20599		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	>						mbridge		21613	Approximate	
cate be executed which is provided by special and burial-transit is the burial-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, kaning to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as	a consequa	ence of):	Lur	g wi	/K 2	netas	Lasis		Onset and D	Batti
the death certif y the attending iched for use a	Physician/Med	IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal	death 3	Ectopic pregr Other (specif				230	d. Date of deliv		ear
uires that n signed b	by	Part II. Other significant conditions cont	ributing to death be	ut not resu	lting in the u	nderlying caus	e given in Pai	t I.				the cause of de bably 4 □Ui	
sician: The law requires to certificate has been signe irector, page 2 should be	ompleted								24a. Was a autops perform	SV .	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings a ompletion of ca	vailable use of
sician: Tector, p	BeC	25. Was case referred to medical examiner?							(Check only or				
_ ≥ .ഈ ⊅	2	1 ☐ Yes 2 ☑ No	ospital: 1 Inpatie			nt 3 DOA	Other: 4		me 5 Resid			(fy)	
	00	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Inju (Month, Day	ry y Ye <i>ar)</i>	28b. Time o Injury		Injury at Work?		28d. Describe h	ow injury o	occurred		
Atten	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc.	ury - At hor c. (Specify)	me, farm, str	M reet, factory, of	1 Yes 2		28f. Location (S City or Tow		Number or Rur	al Route Numb	Der,
Hospita 4 hours Funeral ely fillec	edical C	29a. Certifier 1 ☐ Certifying Physi (Check only one) 2 ☐ Medical Examin	ician: To the best of er: On the basis of and manner sta	f examinati ated.	ion and/or in	vestigation, in	my opinion, d	eath occurr	ed at the time, o	ate and pl	ace, and due t	o the cause(s)	
To tha I within 2 To tha Complet	Me	29b. Signature and title of certifier	M MD			29c. L	cense numbe	659	CAMSI	9d. Date s	signed (Month,	Day, Year)	
		30. Name and address of person who cor	AFZA	leath (Item	23а) (Турө, Зоо	Print	RA S	7, 0	CAMBI	2104	E, 1	ND -21	613
St Regist	ate rar	31. Date filed (Month, Day, Year)	2006 32. Registra	ar's Signat	Mre June	front	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Dav Year **Physician** 1029 20 2006 March /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Social Security Number Country) 1 □ M 2 D F Months Yrs. Director Naryland none 10 March 20 2006 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner rust be notified at 1 Yes 21 No Directo Talbot Trappe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ ea 5 n wat items 23e 5 216 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Ño If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: γ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Black "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ber Renee homas oria 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 so to of Health an it if item 27 is MD.21673 7-Ocean Gateway -5 Mer oria rappe. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Cambridge, Maryland Mid Shore Cremation 3/27/06 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P. A. HENRY FUNERal 21613 510 Washington St. Cambridge, 23a. Party Enter the disease, or complications that caused the death. shock, or heart failure. List only one caus for each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician emout /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2⊠No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 Natural death. 2 🗌 Accident 1 ☐ Yes 2 ☐ No after death 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerei D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

State Registrar

29b. Signature and title of certified

Landy M. 31. Date filed (Month,

DHMH 17 Rev 1/2001

Cook, M.D.,606 Dutchman's Lane, Easton, MD

29c. License number

000

29d. Date signed (Month, Day, Year)

and manner stated.

2 4 2006^{32. Resistrar's Signature}

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	State of Maryland / D	epartment of Health and Mental Hyg	•
	1 - State Registrar	Certificate of Death	2000 1002 / Reg. No.
Physician	Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Year Oo-
/Medica	Marjorie Heren Phippin	4b. City, Town, or Location of Death	22 206 0305 M
Examiner	Dorchester General Hospital	Cambridge	Dorchester
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day	9. Birthplace (State or Foreign Country)
Director	217-12-4133 1 M 2 F 82 Y Usual Residence of Decedent	May 22	, 1923 Maryland
Maryland 1 show	10a. State 10b. County 10c. City, Town		10d. Inside City Limits
Be-1-	MD Dorchester	Cambridge	1.XYes 2 No
With II with II Direct	10e. Street and Number 400 Shepherd Ave.	10f. Zip Code 21613	10g. Citizen of What Country? USA
death death	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
36 36 safter aming	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes. 2 ☑ No If Yes, Give Year, or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: white
21215-0036 21215-0036 30 within 72 hours after death with the Mar yejene. The Martical Examiner must be notified in the Martical Examiner must be notified.	15. Decedent's Education 16a. [Decedent's Usual Occupation	16b. Kind of Business/Industry
215 215 215 215 215 215 215 215 215 215	(Specify only highest grade completed) (Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of working life. DO NOT use retired)	1000
Miled w Hygier than the state of the state o	10 17. Father's Name (First, Middle, Last)	homemaker 18. Mother's Name (First, Middle,	own home Maiden Sumame)
Maryland 2121 Maryland 2121 d 2 should be filed within th and Mental Hygiene. 77 is marked other then: treumetic event, the Maryland Re Compiler	George Riley Andrews	Margie Helen A	ndrews
Lary 2 shou and M is mail sum the eumet	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rural Route Number	
ore, Ma ss 1 end 2 s of Health ar litem 27 is		00 She herd Ave., Cambridge Disposition (Name of crematory or other place) Date	MD 21613 20c. Location - City or Town, State
altimore, rmit. Pages 1 er spartment of Hea portent: if item portent: gigt.	1 Abunal 2 Uremation 3 Hemoval from State	ve Churchyard 3/26/06	Church Creek, MD
Baltimore, Maryland 21215-0036 Baltimore, Maryland 21215-0036 Permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. To how min protection: If them 27 is marked other then "naturel", or items 23s or 28s-1 show min portent: If them 27 is marked other then "naturel" or them 23s or 28s-1 show min protection: To Re Completed by Euneral Director	21. Signature of Funeral Service Licensee		neral Home P.A.
W SOESS	Buik Bu	700 Locust St., Cambridge	
	23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death) a. Light temps	oparietal occipital infarct	10 days
Examiner	Sequentially list conditions, b.		
executed on and ial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	Ε	
8760, ate be executed hysicien and the burial-transit	•):	
Box 68760, death certificate be executed e attending physicien and id for use as the burial-transit			
ds, P.O. Box 68 uires that the death certifica signed by the attending pt d be detached for use as it d by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
	in the past 12 months? □ Yes 2 No □ Uyes 2 No □ Uyes 2 No □ Uyes 2 No	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
P.O. nat the did the did the did the did the did the did the elached	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in t	ha undahira ayan in Badil 22a Didita	bacco use contribute to the cause of death?
ords, P.O requires that the seen signed by the hould be detached by the hould be detached by the steed by Physical purples of the purples of	C LL 00	and an administration of the state of the st	es 2 KNo 3 Probably 4 Unknown
w request should	0	24a. Was a	an 24b. Were autopsy findings available
Il Record The law requir ate has been s page 2 should		autops perform 1 Yes	med? death?
Vita icien: certific ector.	25. Was case referred to medical examiner?	26. Place of Death (Check only or	
of N Physi or this o	1 Tes 2 2 No 1 Mountaint 2 LEPOUtp	me of 28c. Injury at 28d. Describe ho	ence 6 Other (Specify) ow injury occurred
sion anding ath. or: Afte	1 XNatural 5 Pending (Month, Day Year) Injury 2 Accident investigation	ury Work? M 1 ☐ Yes 2 ☐ No	
Division of Vital Records, tel or Attending Physicien: The law requires the after death. el Director: After this certificate has been signe ed in by the funeral director, page 2 should be coertification: To Be Completed by	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28f. Location (Si City or Town	itreet and Number or Rural Route Number, n, State)
Spitel nours a		death occurred at the time, date and place, and due to the c	
Division of Vital Record To the Hospitel or Attending Physicien: The law requir within 24 hours after death. To the Funerel Director: After this certificate has been si completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	(Check only one) 2 Medical Examiner: On the basis of examination and/one) and manner stated.	or investigation, in my opinion, death occurred at the time, d	
To To To Con	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a) (T	DS0804	3-22-06
	Mark Malkus, M.D. 408 Byrn	Street Cambridge, MD	31613
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signatule	And I	
3,44,6	The state of the s		

			1- State of Maryland / D Registrar	epartment of H Certificate of I			ene J. No.	10828
	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	20, 2006	3. Time of Death
	/Medic	al	Mary Lillian Pinkney 4a. Facility Name (If not institution, give street and number)	4b. City. Town, or	Location of Death	March 2	4c. County of Deat	12:30PM
	Examin	er	Bradford Oaks Nursing Home	Clinton			Prince (
	Funeral Director		217 32 3301 1 00	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 7 / 1 6 / 1 9	9. Birt Co 25 Mai	hplace (State or Foreign buntry) cyland
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	Maryl I sho	tor	MD Charles Waldo	rf				1X Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show rmst.ke n.:Illied at	al Director	10e. Street and Number 2787 Tyburn Oaks Ct.	10f. Zip Code 20	0601	100	J. Citizen of What Co USA	untry?
2-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. d other then "netural", or liems 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼ No	ispanic Origin? (Spe in, Mexican, Puerto f Specify:	city Yes or No- lican, etc.)	14. Race - Ame Black, White Specify: B	
<u>ب</u>	"netui	Completed	(Specify only highest grade completed)	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired	during most of workir	ng 16	6b. Kind of Business/	Industry
7 7	e filed within all Hygiene. other then "I	omp	Elementary/Secondary (0-12) College (1-4or 5+)	od Server		E	soard of	Education
פר	e filed al Hygid cother vent,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name			
yland		To	John McNeil		Rosie H	awkins		
Mar	12 shound and 7 le m			Mailing Address (Street a			-	
a)	s 1 and 2 should I Health and Mer item 27 le marke other treumatic		Geraldine Bethea/Daughter 276 20a. Method of Disposition 20b. Place of	Disposition (Name of	. D		OCI, MD	
Бапптог	t. Page rtment o rtent: If njury or		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature Ineral Service Licensee)	riematory or other place Thomas 22. Name and Addres	3/24	1/06	Baden, M	aryland
g	permi Depa Impo eny ir		Loyal 191	Adams Fu	neral Ho	me, PA AQUA	20605 Ac SCO, MD	quasco Rd. 20608
	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or theart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence or	ers Dise		respiratory arres	t,	Approximate Interval Batween Onset and Death
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Tissess of 1914) that initiated events):				
_	xecute and II-trans	Examiner	Cause (1ses of 17 11) that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8/60	lificate be executed g physician and as the burial-transit	edicai E	d					· · · · · · · · · · · · · · · · · · ·
O. BOX 6	death cer e attendin nd for use	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		(4)	23d. Date of del Month	ivery Day Year
cords, P	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
T T	The favate has	Completed				24a. Was an autopsy performe	prior to death?	itopsy findings available completion of cause of 2 No
VII	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Oth.	26. Place of Death	(Check only one)		
0		- To	1		4 Nursing Hon	ne 5 Residen	ce 6 ☐Other (Spec	cify)
	Attending r death. ector; After by the funer	tion		ury Worl	k? Yes 2 □ No	dd. Describe now	injury occurred	
DIVISION	ol or Atten after dea Director d in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fame building, etc. (Specify)	m, street, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director; After this completely filled in by the funeral di	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medicat Examiner: On the basis of examination and manner stated.					
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License	e number	290	I. Date signed (Monti	h, Day, Year)
^			With James	736	7206		noch 21	2W6
(DB		30. Name and address of person who completed cause of death (Item 23a) (TWILLIAM T. TAWNER LINE 1170	ype, Print)	en Kont.	Fat WAS	Mulga 1	months
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (The William T. TAWKEN UN 1170) 31. Date filed (Month, Day, Year) MAR 2 3 2008 32. Figistrar's Signature	Sparke				,

			1- State of Ma	ryland / [Department of F Certificate of		ental Hygier Reg. I	211116	10829
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
н	Physici /Medio		LUCY PULLINS					8, 2006	2:25 P ^M
4	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death		4c. County of Death	
			418 FAIRMONT DRIVE		EDGEWAT		Z	ANNE ARUNI	DEL
	Funeral		1□M 3√2 F	(In yrs. last bir	Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea	ar) 9. Birthi	olace (State or Foreign ntry)
	Director		Usual Residence of Decedent	76	Yrs.		JUNE 22,	1929 WASH	INGTON D.C.
	land ow		10a. State 10b. County	10c. City, Tow	n or Location	·			10d. Inside City Limits
	Mary if sh	ţ	MARYLAND ANNE ARUNDEL	EDGEWA	ਪਾਜ਼ਲ				1 ☐ Yes 2 ☐ No
	r 28a	Directo	10e. Street and Number	DODWY	10f. Zip Code		10g.	Citizen of What Cou	
	h with		418 FAIRMONT DRIVE		21037		FINT	TED STATE	c
	eep E	Funeral	11. Maritaf Status 12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Decedent of H	dispanic Origin? (Spec		14. Race - Americ Bfack, White,	can Indian,
36	within 72 hours after deeth with the Maryland ene. then "natural", or teme 23s or 28s-f ehow the M-clost Exercites must be mutified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ N ## Yes, Give 1 ☐ Yes 2 ▼ N ## Yes, Give Year or Dates:	0	1 ☐ Yes 2 No	Specify:	, oto.,	Specify:	
2-0036	n 72 hours "natural", olcal Ext	edk	15. Decedent's Education	16a	. Decedent's Usual Occup	pation	16b	WHI Kind of Business/In	
5	n ne	Completed	(Specify only highest grade completed)		(Give kind of work done life. DO NOT use retired	during most of working	7	. reside of odds loods	ddolly
212	filed within Hygiene.	E o	Elementary/Secondary (0-12) Coflege (1-4or 5-		OMEMAKER		HO	ME	
ğ	be filed within tal Hygiene. d other then event, the Manager the M	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maid	len Sumame)	
<u>a</u>		To E	GUISEPPI DARCANGELO			FIORINA	MARINO		
Maryland	s 1 and 2 should f Health and Men Item 27 le marke other traumatic	i	19a. Informant's Name/Relationship (Type, Print)	196	o. Mailing Address (Street	and Number or Rural	Route Number, Cit	y or Town, State, Zip	Code)
	1 and 2 Health tem 27 l		JAMES J. PULLINS (SON)		190 ROLLING		EWATER, M	D. 21037	
ore	of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State	20b. Place of cemete	of Disposition (Name of ery, crematory or other place	Da	te 20c.	Location - City or To	own, State
Ē	Pages ment of tant: If It jury or o		4 ☐ Donation 5 ☐ Other (Specify)	MARYL	AND VETERANS			OWNSVILLE	,MD.
Baltimore,	permit. Pages Department of Important: If II eny injury or c		21. Signature of Funeral Service Licensee		22. Name and Addre	ss of Facility GEORG	E P. KAL	AS FUNERA	L HOME
	20 = 0		Mod em	22	2973 SOLOM	IONS ISLAND	ROAD E	DGEWATER,	MD. 21037
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	Θ.		-			Approximate Interval Between Onset and Death
	Physician		fmmediate Cause (Final disease or condition resulting in death) a	Ken	NAL FO	MILVRE			5 YEAR
	/Medical Examiner		Due to (or as a	consequence	of):	11110007	20%		in ilan
		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	GENER a consequence		V + L V / / / / /	/ //).	/	o yerra
	uted	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,				
,	execting and ital-tra	Examine	and the state of t	consequence	of):				
28/60	ficate be executed physician and is the burial-transit	edical	d						
_	E 79 m	Medi	# FEMALE					1	
ROX	death certifie attending	an/h	fF FEMALE: 23b. Was decedent pregnant 1 □ Live birth	of pregnancy 2 Fetal death	n 3 □Ectopic pregnancy	,		23d. Date of delive	•
	0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		5 Other (specify)			Month	Day Year
P.O.	res that the de signed by the a be detached f	Phy	Part fl. Other significant conditions contributing to death bu	et not resulting i	n the underlying cause any	en in Part I	23e Did tobaco	o use contribute to t	he cause of death?
ds,	The law requires that the tee bas been signed by the base should be detache	d by	CONGESTIVE Hel				1 Tes	h .	pably 4 □Unknown
ö	w require been sig should t	ete					24a. Was an	Oah Mass suss	psy findings available
ě	he fav s has ge 2	Completed					autopsy performed	prior to co death?	impletion of cause of
g			25. Was case referred to medical			OS Dines of Death	1 Yes 2	No 1 ☐ Yes	2 No
5	hysicien: The la his certificate has I director, page 2	To Be	examiner? 1 ☐ Yes 2 ☒ No	nt 2□ FB/Oı	utpatient 3 DOA Oth	26. Pface of Death (6 ☐Other (Specif	
Ö	Attending Physicien: In death. Sector: After this certifice by the funeral director, to		27. Manner of Death 28a. Date of fnjun	y 28b.	Time of 28c. Injur		d. Describe how in		77
<u>o</u>	ath. r: Aft	atlo	1 XNaturaf 5 □ Pending (Month, Day 2 □ Accident investigation	rear)		Yes 2□No			
Division of Vital Records,	or Attend efter death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju building, etc	ry - At home, fa . (Specify)	arm, street, factory, office	28	f. Location (Street City or Town, St.	and Number or Rura ate)	ıl Route Number,
	urs el eral D		Continue of Contin						
	To the Moepital or Al within 24 hours efter of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination an	e, death occurred at the tir nd/or investigation, in my o	ne, date and place, an pinion, death occurred	d due to the cause Lat the time, date a	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	111	29c. Licens			Date signed (Month,	•
,			Marvey of Sheer	for	10	7158	MAF	RCH 20,200	6
			30. Name and address of person who completed cause of de	ath (ftem 23a)	(Type, Print) 6/ -	5 1 5 8 31 5HM	0 510-	e RD	764
	Sta	to.	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	11111	114 511) -	e. ////	10	, , ,
	Registr		MAR 2 2 2006	2 236	Conte				

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/200

State

Registrar

10

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

WILLIAM T. TANNER, M.D.

MAR 2 3 2006

Verse n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

D35206

11701 LIVINGSTON RD.

29d. Date signed (Month. Dav. Year)

MARCH 19, 2006

FORT WASHINGTON, MD 20744

an al er	1 - State Registrar 1. Decedent's Name (First, Middle, Last) CAROLYN VIRGINIA		Cei	rtificate of E	Jooth		Z 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 1 1 1 1 1 1 1
al .				uncate of L	Jean I		eg. No.	10001
al .	CAROLYN VTRGTNTA					Date of Deat Month	h Day Year	
er						March 1		3:50p ^M
	4a. Facility Name (If not institution, give :	,		4b. City, Town, or			4c. County of De	
	608 Knightsbridg 5. Social Security Number 6. Security Number		et hirthday)	Hagerst	OWN If Under 24 Hrs.	9 Date of Birth	Washing	
		M 2 → 77	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 23,	Year) 1928 Non	rthplace (State or Foreign Country) th Carolina
	10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
tor	Maryland Washingt	on Hag	gersto	own				1∭Yes 2□No
)ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
a	608 Knightsbridg	e Drive		21740			U.S.A.	
nue		Armed Forces?	. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		
y F		If Yes, Give		1 ☐ Yes 2 No	Specify:		Specify: T.	há e a
pa			16a Daca	dent's Lisual Occupa	tion			hite
olet	(Specify only highest grade	completed)	(Give	kind of work done d DO NOT use retired)	uring most of work	ing	TOD. Kille of Besilles	windustry
m ₀	Elementary/Secondary (0-12)	College (1-4or 5+)					Metropolit	an Lithograph
	17. Father's Name (First, Middle, Last)				18. Mother's Name			
O.	Joseph James Cod	у			Flora H	enderson		
-	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	al Route Number	, City or Town, State,	Zip Code)
	Debby A. Jorgens					Hagerst	own, Mary	land 21740
	20a. Method of Disposition	20b. Pla	ce of Dispo	osition (Name of matory or other place	,	Date	20c. Location - City of	r Town, State
	'4 □ Donation 5 □ Other (Specify)		Linco	ln Cemetery	3/22	/2006	Brentwood	, Maryland
	21. Signature of Funeral Service Licensi	27 /						
	Hallut (1	1/0/4						20781
j	Immediate Cause (Final diseas) or condition resulting in death)	Small Bowel Oue to (or as a conseque Ovarian Mass	ence of):	uction				Interval Between Onset and Death
Ical	resulting in death) Last	Due to (or as a conseque						
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live birth 2 ☐ Fetal o	death 3				23d. Date of d Month	elivery Day Year
	Part II. Other significant conditions cor	tributing to death but not result	ting in the u	nderlying cause give	n in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
d be	Poor Compliance,	Coronary Arter	ry Dia	sease,		1 □ Ye	es 2□No 3□F	Probably 4 XUnknown
ojet	Atrial Fiberillat	ion						autopsy findings available
шо						perforr	ned? death?	
a	25. Was case referred to medical				26 Place of Deat		FE	15 2 NO
0	examiner? 1 ☐ Yes 2 🏋 No	ospital: 1 Inpatient 2 E	R/Outpatier	nt 3 DOA Othe				ecify)
	27. Manner of Death	28a. Date of Injury						20.197
atlo	2 ☐ Accident investigation	(Monal, Day 16a)	mjary					
Sertific	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, st	reet, factory, office				Rural Route Number,
	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, deat on and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Mor	nth, Day, Year)
	199			Doo	50002	>	March 21.	2006
	30. Name and address of person who co	mpleted cause of death (Item :	23а) (Туре,	Print)				
					s Road	107. Ha	oeretown	MD 217/2
	Medical Certification: To Be Completed by Physician/Medi	Joseph James Cod 19a. Informant's Name/Relationship (Tyr Debby A. Jorgens 20a. Method of Disposition 1	17. Father's Name (First, Middle, Last) Joseph James Cody	17. Father's Name (First, Middle, Last) Joseph James Cody 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Debby A. Jorgensen - Daughter 9730 20a. Method of Disposition 1	19a Informant's Name (First, Middle, Last) Joseph James Cody 19a Informant's Name (First, Middle, Last) Debby A. Jorgensen — Daughter 9730 Sharpsbu 20a Method of Disposition 3 Removal from State 20b Place of Disposition (Name of camalety, crematory or other place) 1	19. Mother's Name 19.	Joseph James Cody 19a. Informant's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Plural Route Number 1973 Of Sharpsburg Pike, Hagerst 20a Method of Disposition 1	Joseph James Cody Joseph James Cody Flora Henderson Flora H

/Medical Examiner Funeral Director	4a. Facility Name (If not institution Washington Coun 5. Social Security Number	n, give street and numb ty Hospital									006	X: 401
Director			L		Hage	rsto	ocation of I		March	4c. Count		n
_	219-20-1382 Usual Residence of Decedent	6. Sex 7. 1 □ M 2 🕱 F	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min.	8. Date of Bi (Month, Di Sept. 2	2, 1926	Coun	ace (State or Fore try) Land
tor 28a-f show	10a. State 10b. County Maryland Freder 10e. Street and Number			, Town or Loo		Code				10g. Citizen of		od. Inside City Lim 1 Yes 2 try?
of, or Iteme 23s Example must by Funeral		12. Was Deced Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ⊈ ∏No	16a. Deced	Yes 2	int of His y Cuban No	Specify:		city Yes or Nacional Research		ce - Americ lck, White, of fy: Whit	an Indian, etc.
Hygiene. other then "nature ent, the Medical I	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle,	St grade completed) College (1-4 Last)	ior 5+)	Homen	kind of work OO NOT use naker	retired)				Own Ho		
in and Mental Hygiene. If Is marked other then traumatic event, Its M. To Be Compi	Charles C. Ford 19a. Informant's Name/Relations Sylvia Lantz/ D	ship (Type, Print)				Street ar	Sadie	Mae or Rural	Kinna Route Numb	per, City or Town	, State, Zip	Code)
Important: If item 27 any injury or other tra	20a. Method of Disposition 1 ABurial 2 Cremation 4 Donation 5 Other (S	3 □Removal from St	ate _ ce	ace of Dispos metery, crem	sition (Name natory or oth emete	e of er place ry	3/	^{'24/2}	ate 2006	20c. Location	· City or To	yland
any ni	21. Signature of Funeral Service	Ligense		16	Name and	Address OSSU	of Facility	Stau Pil	uffer l ke, Fre	Funeral ederick,	Home, MD 2	P.A. 1702
physicien and the burial-transit and dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	o SE r as a consequ	ence of):	>							nknow
been signed by the ettending ph should be detached for use as the leted by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		h 2∏Fetal nt at time of de	death 3 🗆	Ectopic pre						ate of delive	ry Day Year
een signed bould be deta	Part II. Other significant condition De men Hyper K			lting in the ur	derlying car	use giver	in Part I.			tobacco use con Yes 2 □ No	tribute to th	1.
page 2	HYPEY K 25. Was case referred to medica		-				36 Plana o	of Dogsth	24a. Was auto peri 1 Yes	psy ormed? 2 No	prior to con death?	osy findings avail npletion of cause 2 No
After this funeral c	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendi 2 Accident invest	28a. Date of	Injury Day Year)	ER/Outpatient 28b. Time of Injury		Other c. injury Work?	4 🗌 Nurs	ing Hom	ne 5□ Aes	idence 6 Otl		')
To the Funeral Director: completely filled in by the Medical Certifical	3 Suicide 6 Could 4 Homicide detern 29a. Certifier X Certifyii	nined 289. Place o	f Injury - At hor g, etc. (Specify))			data and		City or To	(Street and Num. wn, State)		
he Funeral I pletely filled edical Ce		ng Friysician. To the D	is of examinati r stated.	ion and/or inv	estigation, i	n my opi	nion, death	occurre	ed at the time.	date and place,	anner as st and due to	ated. the cause(s)

			1 - For State Registrar	State of Maryl	and / Depa	ırtment o		nd Mental F		e 0 6	10833
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of		ay Year	3. Time of Death
	Physici /Medio		Mabelle Alice Re					March March	23,	2006	11:50 PM
	Examin	er	4a. Facility Name (If not institution, give s	reet and number)			wn, or Location of	Death		c. County of Death	
			Gilchrist Hospice 5. Social Security Number 6. Sex	7 Ann (In)	una danad birat al- N	Towso		d Hro		altimore	
	Funeral Director			M 201 F	yrs. last birthday) 92 Yrs.	Months D	Days Hours	Min. 8. Date of (Month, Oct 2	Day, Yea	913 Mass	lace (State or Foreign try) achusetts
	filed within 72 hours after death with the Maryland Hygiene. ither then "naturel", or tems 23a or 28a-f show ent, the Medical Examination must be ricitited at		10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	e Mai	ctor	Maryland Howard	E1:	licott C	itv					1 ☐ Yes 2 📉 No
	if the	Directo	10e. Street and Number			10f. Zip Co	ode		10g. C	itizen of What Coun	itry?
	ath w	ral	3004 N. Ridge Road			2104			USA		
	er de	Funeral		Was Decedent Ever i Armed Forces?	n U.S. 13. V	Vas Deceden Yes, specify	t of Hispanic Origi Cuban, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Americ Black, White,	
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 📉 No If Yes, Give Year or Dates:	1	□Yes 2X	No Specify:			Specify: White	
ŏ	2 hou	ted	15. Decedent's Educ	ation	16a. Deced	ent's Usual C	Occupation		16b.	Wnite Kind of Business/Inc	e
215	hin 72	pie	(Specify only highest grade Elementary/Secondary (0.12)	Completed) College (1-4or 5+)	(Give	kind of work o	done during most of	of working	100.	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Justry
21,	giene giene	Completed	Elementary/occordary (0 12)	2	Secre	tary			Ed	ucation	
P	a! Hy a! Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother	s Name (First, Mide	dle, Maide	n Sumame)	
<u>ya</u>	should be and Mental marked c	ပ	Walter Perley Schwa					Louise Ri			
Nar	and reum		19a. Informant's Name/Relationship (Type							or Town, State, Zip	Code)
e,	1 and Health em 27 ther tr		Christine A. Brobec	THE PERSON NAMED IN COLUMN 1				t Columbi	_		0
Baitimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat interstraint of collection and once.		1 ☐ Burial 2X Cremation 3 ☐ Re	movar nom State	b. Place of Dispos cemetery, crem			March 25,	1	Location - City or To	
į	nit. P artme ortan injuri		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		hesapeak			2006		tsville, l	
B	Departiment of the poor of the			11118	0/25/ G	oing H	ome Crem	ation Ser	vice	P.O. Box	x 784
			23a. Pan1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the d	eath. Do not ente	everly or the mode o	L. Heck: f dying, such as ca	rotte, P. ardiac or respirator	arrest,	larksvill	Approximate
	Physician		Immediate Cause (Final disease or condition	Complica	ATO NA	04	1 :	acture		X-(Onset and Death
	/Medical		resulting in death)	Due to (or as a con			of Fr	a Cool E	-	2.	weks
	Examiner		Sequentially list conditions, b.					2	2	NO NO	
Z	be isi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con:	sequence of):			500/	M	101	
2 -	ate be executed hysicien and the burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a con-	sequence of):			R	7/7	\$	
1.50 8760,	e be e	ical E						<i>X</i> -X-XX	Will		
- 9	tificat ig phy as th	edi	u.						3		
Box	eath certifica ettending pl for use as t	N/ug	200. Was decodorit programit	c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pregr		No.		23d. Date of delive	ry
子 · ·	ne dea the ett hed fo	sicia	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time of		Other (specif			-	Month	Day Year
@ O.	that the death certific ed by the ettending p detached for use as	by Physician/Med	9 Unknown		and the state of						
PER 3/23/06 of Vital Records,	w requires that been signed to should be det	d by	Part II. Other significant conditions cont	ributing to death but not	nu enti ni gnittuseri	derlying caus	e given in Part I.			use contribute to th	
23/	v requ	Completed								2 □ No 3 □ Proba	
Re W	he lav	du						24a. W	topsy	prior to con	osy findings available opletion of cause of
<u></u>	Physician: The this certificate har director, page	မ လ	25. Was case referred to medical				17.47	7.50	rfórmed? 2 ☑ N	o 1 Yes	2 No
of Vi	s cert	To B	examiner?	spital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatient	2□ DOA		f Death (Check on		6 Other (Specify	Jacqui
	g Phy er thi		27. Manner of Death	28a. Date of Injury	28b. Time of		Injury at	28d. Describ	e how inj	6 Officer (Specify occurred	PIWPIQ
를 io	ath. rr: Aft	atio	1 ☐ Natural 5 ☐ Pending 2 ☑ Accident investigation	(Month, Day Year G 200		AM .	Work? 1 ☐ Yes 2 ☑ No	Fall	from:	standing	
Magel L Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, stre	-	fice	28f. Location	(Street a	and Number or Rural	Route Number,
\$ 0	ital o			Home				3004 N.	Ritge	Rd Ellicott	City, MD
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the estending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medicai	29a. Certifier Certifying Physic Construction 2 Medical Examine	cian: To the best of my	knowledge, death nnation and/or inv	occurred at the	he time, date and my opinion, death	place and due to th	on coursel	a) and minanas as -1-	
	thin 2 the mplei	Med	29b. Signature and title of certifier	and manner stated.			cense number				
	5 7 £ 7		Allan	~~~		1 -	58303		Ī	ate signed (Month, E Ch 24 20	
	p		30. Name and address of person who com	noleted cause of death //	Itom 22a) /T 5	-		111111		,	~
٤.	6.8	T Y	30. Name and address of person who com AAAAN CHALES, V 31. Date filed (Month, Day, Year) MAR 2, 4 201	ND GOIN	- Charles	ST	Borns	re mo à	2120	4	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature					,	
	Registr	ar	MAR 2 4 201	16 Been	N. Page						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		ne o			
ì	U	Ö	Ű	1-3	

9. Birthplace (State or Foreign

10d. Inside City Limits

XX Yes 2 No

Maryland

4c. County of Death

10g. Citizen of What Country?

United States

white

16b. Kind of Business/Industry

Tax Preparation

20c. Location - City or Town, State

Westernport, Maryland

21562

Approximate Interval Between Onset and Death

6months

14. Race - American Indian, Black, White, etc.

Year) 1928

been signed by the e should be detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p. For State Registrer

ſ	Due to (or as a consequence of):			
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or as a consequence of):			
that initiated events resulting in death) Last	C. Due to (or as a consequence of): d.			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		topic pregnancy her (specify)		23d. Date of delivery Month Day Yea
	ontributing to death but not resulting in the under the Heart Failure			o use contribute to the cause of dea
			24a. Was an autopsy performed:	
25. Was case referred to medicat examiner?		26. Place of Dea	th (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4□ Nursing H	ome 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how in	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number ate)
29a. Certifier 1 Certifying Ph (Check only one)	ysicien: To the best of my knowledge, death or niner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, tigation, in my opinion, death occur	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	lesher MD	29c. License number 0005532		Date signed (Month, Day, Year) Muzch 24, 207

Tenace Frostburg MD21532 WONSOCK SHIN MD 48 Town 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 7 2006

Registrar

CotVA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:40 PM Bernard W. Samm, Sr. 19,2006 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** National Lutheran Home Rockville Montgomery Co. 8. Date of Birth (Month, Day Ye Jan. 20, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** , 1912 **X**□M 2□F 215-05-1024 94 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 28e-f show 10d. Inside City Limits or Items 23e or 28e-f shover in all restricted at Md. Montgomery Rockville 1XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701-Veirs Dr., 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic avant, If a Modical Exacutive D Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No þ Specify: White Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If itam 27 is marked other then any injury or other traumatic avant, If a M. Elementary/Secondary (0-12) College (1-4or 5+) Manager Dry Cleaners 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert C. Samm Augusta Lockhardt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Hughes- Executor 9701-Veirs Dr., Rockville, Md. 20850 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Wall Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Gard-3/24/06- Timonium, Md. `4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility once. Hysong Co., Inc.
6510-16th St., NW, Wash., DC
each line
each line
each line 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one callse of Approximate Interval Between Onset and Death Immediate Cause (Final Physician vac resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy jo Month Year 4 Pregnant at time of death 5 Other (specify) detached (9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Pe 2 PNo 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 2 ZINO Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 University Home 5 Residence 6 Other (Specify) ပ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 12:50 P 5 Pending 1 Yes 2 2No death. 3/13/2006 all 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 28f. a Funarel Diract filled in by 4 Homicide ee ievs 29a. Certifier (Check only one) l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 March 27 res 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Charles Karesh-9701-Veirs Dr., Rockville, Md. 20850 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar MAR 2 3 2006

			1 - For State Registrar Amend#27.Per:Phy	State of Marylands PCC 3-27-06cm		artment of H tificate of L			ene g. No.	<u>.</u>	10836
	Physici	an	1. Decedent's Name (First, Middle, Last) Dolores J. Smit	- h				2. Date of Death Month March		Year 006	3. Time of Death 11:55A M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of		11.3311
		¥0 —	4902 Foley Terra				ple Hill				George's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign ntry)
No.	Director		243-68-2970 Usual Residence of Decedent	62				Nov. 20	, 1943	Mt.	Gilead, NC
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	e Ma	ctor	Maryland Prince G	eorge's		Capitol H	leights				1X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W		,
	death with the Maryland me 23a or 28a-f show rmust be notified at	erai	4167 Southern		6 12 1	Man Danadani al III	20743				States
	be filed within 72 hours after death with the Marylar Hygiene. d other then "naturel", or iteme 23a or 28a-f show event. Its Modical Examinar must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2X No	Specify:	Rican, etc.)	Black Specify:	, White Af	en Indian, etc. rican erican
0500-c1	72 hou	Completed	15. Decedent's Educ	ation	16a. Decec	dent's Usual Occupa	ation	1	6b. Kind of Bus		
Z	ithin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. L	kind of work done of DO NOT use retired	i)	Virig			
7	filed w Hygier ther th		12th 17. Father's Name (First, Middle, Last)		Ce	rtified N		e (First, Middle, M		ivat	e
≧		Be C		ooley, Jr.				Maxine E		′	
>	2 should be and Mental is marked sumatic ev	ပ	19a. Informant's Name/Relationship (Typ		19b. Mailin	ng Address (Street a		ral Route Number,			Code)
Ž	127 H		Pannie M. William	ms/Daughter		-		Temple H			0748
e G	es 1 a of Hes fitam rothe		20a. Method of Disposition 1	1 -	lace of Dispo	sition (Name of natory or other plac	e)	Date 2	Oc. Location - 0	City or To	own, State
baltimore,	permit. Pages Depertment of I Important: if its any injury or o ance.		4 □ Donation 5 □ Other (Specify)	Ft.	Linco	1n Cemete		3/2006	Brenty		
g	permit Deper Impor Impor Impor		21. Signature of Freeral Service License		22	. Name and Addres		tewart F			
	40244		23a Part 1 Friter the disease or complic	rations that caused the death	Do not ent		_	or respiratory area	-	DC Z	Approximate
	\$: .		23a. Part1. Enter the disease, or complic shock, of heart failure. List only on Immediate Cause (Final	e cause on each line.		or the mode or dynn	g, such as cardiac	or respiratory arre-	51,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):	haryr	W.				
	Examiner		Constant the line and distance	2 - 0 (0) 40 4 00 100 100 100 100 100 100 100 100	3.7.	1					
	p :=	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ranes of).						
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	.aaaa af\.					_	
၌	ificete be executed g physicien and as the burial-transit			Due to (or as a consequ	ience or,						
09/80	ficete p phys s the	edicai	d								
X D D		N/M	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregna		le			23d. Date	ol delive	эгу
	death cer ne attendin ed for use	sicia	in the past 12 months? 1 ☐ Yes 2. ☐ No	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown]Ectopic pregnancy] Other (specify)			Mon	ith	Day Year
5	at the	Physician/M	9 Unknown								
Š	sicien: The law requires that the de cernificate hes been signed by the , rector, page 2 should be detached	Ď	Part II. Other significant conditions con	Inbuting to death but not resu	Ilting in the ur	nderlying cause give	en in Part I.				ne cause of death?
	requi	Completed					-			3 Prob	
ě	The law ste hes t bage 2 s	mpi			· · · · · · · · · · · · · · · · · · ·			24a. Was an autopsy perform	pr	Vere auto rior to co eath?	psy findings available mpletion of cause of
	in: Tr ificate or, pa	င္ပ	25. Was case referred to medical				00 Blace of Dec	1□ Yes 2	No 1	☐Yes	2 No
>	ysicie s cert directi	0 B	examiner?	ospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Othe		th <i>Check</i> only one		iD Smanni	hter's home
וס ר	ng Ph ter thi	n: T	27. Manner ol Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe how			witer s nome
<u> </u>	endir eath. or: Af	atic	2 Accident investigation		,,		Yes 2 □ No				
DIVISION	or Att	Certification:	3 Suicide Satemined	28e. Place of Injury - At he building, etc. (Specify	me, larm, str	eet, lactory, office		281. Location (Str. City or Town,	eet and Numbe State)	er or Rura	l Route Number,
_	To the Hospital or Attending Physician: within 24 hours eller death, so the Funarel Director. After this certifica completely filled in by the funeral director.	aj Ce	29a. Certifier ertifying Phys	ician: To the best of my kno	wledge death	occurred at the time	ne, date and place	and due to the co-	usp(e) and man	nner ac a	Pated
	• Hos	ledical	(Crieck only 2 Medical Examin	er: On the basis of examinal and manner stated.	ion and/or in	vestigation, in my of	pinion, death occur	rred at the time, da	te and place, a	nd due to	the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License		29	d. Date signed	(Month,	Day, Year)
			Dr. Nicole	R. Richard	(Sin, D	0 H 00	60781		3/21	120	06
	(5)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	Dr.	Nicole R			n, D.O.
18.00			31. Date filed (Month, Day, Year)	2. Registrar's Signa	Ture .	1tmp	1 Hills	MD:	2074	Υ	
	Sta Registr		MAD 9 9 2006	E. Hogistian's Signa	1	w .					

			1 - State Registrar	State of Mar	•	Departme Certifica				giene Reg. No.	16	10837
4574			Decedent's Name (First, Middle, Las	1)					2. Date of De			3. Time of Death
	Physici		CHARLES WILLI	AM SIGNOR	TNO				Month	2 ^{ay}	2006	2:53 AM
	/Medio		4a. Facility Name (If not institution, give		LIIVO	4b. C	ity, Town, o	Location of De			y of Death	
	Examili	ei	WASHINGTON COUNTY				•	GERSTOW			SHING	TON
	Funeral		5. Social Security Number 6. Se		In yrs. last bir		der 1 Year	If Under 24 H	rs. 8. Date of Bir	th		place (State or Foreign
70.	Director		049-38-6281	XIM 2□ F 5	8	Yrs. Month	ns Days	Hours Mi	n. (Month, Da OCT • 4	19. Year)		ECTICUT
7.7	4 A		Usual Residence of Decedent							,	00212	
	how how		10a. State 10b. County	1	Oc. City, Tow	n or Location					1	0d. Inside City Limits
	a-f	cto	MARYLAND WASHIN	GTON			KE	EDYSVILI	LE			1 X Yes 2 No
	or 28	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of	What Cour	ntry?
	23a		21 ROCKINGHAM DRI	VE				21756	1	U.	S.A.	
	dea dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was De	cedent of H	ispanic Origin?	(Specify Yes or No erto Rican, etc.))- 14. Ra	ce - Americ	
9	or it	E	1 ☐ Never Married 2 🔀 Married	1 ☑ Yes 2 ☐ No If Yes, Give			2 ∑ No	Specify:		Speci	ń.	
8	within 72 hours after death with the Maryland ans. than "natural", or items 23a or 28a-f ehow in Mucleil Exeminar must be mailfied at	d by	3 Widowed 4 Divorced	Year or Dates:						Зрес/	V. V	WHITE
,	72 h	Completed	15. Decedent's Ed (Specify only highest grad		16a.	Decedent's U (Give kind of	work done	during most of w	vorking	16b. Kind of E	Business/In	dustry
2	han n	d E	Elementary/Secondary (0-12)	College (1-4or 5+)		lite. DO NO		,		TATOLIDA	NOT C	30MD 43TS7
7	filed v Hygie other t		12			CLA	IMS A	DJUSTER	(Final 84) day			COMPANY
2	be fi	Be	17. Father's Name (First, Middle, Last)						lame (First, Middle		me)	
<u>~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~</u>	should be filed withir and Mental Hygiene. s marked other than umatic event, the M.	2	ALFRED N. SIGNORI						A. MINGO			
Maryland 21215-0036	~ 42.00 5		19a. Informant's Name/Relationship (7	* * * * * * * * * * * * * * * * * * * *		•			Rural Route Numb			
	s 1 and 2 if Health Itam 27 i		ANN G. SIGNORINO/	SPUUSE	the same	f Disposition (KEEDIS	VILLE, MA	20c. Location	2175	
ğ	permit. Pages Department of h Importent: if Its eny injury or of	-	1 X Burial 2 Cremation 3	Removal from State	cemete	ry, crematory	or other place	· ·			,	
Baltimore,	then tent dury		4 Donation 5 Other (Spenify		BOONS	BORO CI			30/2006		-	MARYLAND
<u>ga</u>	permit. Departr Importe eny inju		21. Signature of Furleyal Sentice Licen	/n_ Paul M	. Dean			ss of Facility AL HOME		ld natio		
-	duz v u		1 all Irya	U					Boonsp	oro,Mar	yland	
			23a. Part . Enter the disease, shock, or heart failure. List only of	one cause on each line.	e death. Do	not enter the n	node of dylr	ig, such as card	iac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a END STI	AGE	MERA	STAT	10 Li	NGC	cercer		
	/Medical Examiner		resulting in death)	Due to (or as a d			_	ſ	0			
R		_	Sequentially list conditions,	b. A (c) e Due to (or as a c		re(+ze(the				
	sit s	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Se os:	consequence	Of):						
_	end end I-trar	Examiner	that initiated events resulting in death) Last	c. Due to for as a c	consequence	of):						
8760,	cate be executed physician end the burial-transit	ᇤ		00010 (01000		0.17.						
387	The law requires that the death certificate be executed ate hes been signed by the attending physician end page 2 should be deteched for use as the burial-transit	dical	•	d	-							
9 X	that the death certific ed by the attending p detached for use as	by Physician/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy					024 D	-44-15-	
Вох	atten for u	lan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tin	☐ Fetal death	3 ☐Ectopio	pregnancy				ate of delivi	өгу Day Year
o	the d	yslc	1 ☐ Yes 2 ☐ 1√0 9 ☐ Unknown	9 Unknown	ne or deam	3 1 0 (1)	(Specify)					
Vital Records, P.O.	that the by detail	F.	Part II. Other significant conditions of	entributing to death but	not resulting i	n the underlyin	g cause giv	en in Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
ds	signed d be del	d b	Hypertension						10	Yes 2□No	3 (DP10)	oably 4 □Unknown
Ö	w requir been si should I	ete							-	2.0		
ě	hes hes 3e 2	Completed							24a. Was		prior to co death?	ppsy findings available impletion of cause of
<u>=</u>	r: Tr								1 ☐ Yes	2 No	1 ☐ Yes	2 No
⋚	ician certif recto	Be	25. Was case reterny to medical examiner?	Hospital:			DOA Oth	05	eath Check only			
o	Phys this ral di	To T	1 Yes 2 No	1 Inpatient		Itpatient 3 Time of	DOA	4 14012111	Home 5 Res	how injury occu		(y)
S	ding h. After fune	lon	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear)	Injury	28c. Injur Wor	k?` Yes 2 □ No	Edd. Boscilbo	now injury occu	11100	
2	deat deat ctor: y the	Ica	3 Suicide 6 Could not be	1	- At home, fa			,00 2 0.10	28f Location	Street and Num	her or Bur	al Route Number.
Division of	after Dire	Certification:	4 - Homicide determined	building, etc.	(Specify)	,,	iory, omico			wn, State)		ar riodio ridinoon,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowleda	e, death occurr	ed at the tir	ne, date and nis	ice, and due to the	cause(s) and n	nanner as s	itated.
	• Ho • Ful etely	edical		iner: On the basis of example and manner state	xamination ar	nd/or investigat	ion, in my c	pinion, death or	ccurred at the time,	date and place	, and due t	o the cause(s)
	To the within 2 To the complet	₹ e	29b. Signature and title of certifier	HOSPITOI	cisi		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
)	. > - 0		17 10	10000000	el.	ı	100	6117		NA 20 (1	יר אי	2006
			30. Name and address of person who	completed cause of dea	th (Item 23a)		,00	O(1/		1 VIGILLY	10	1, 2000
54	-36+1		251 F. Avi	METERN	ST.	+(0	[DS7	MIN	MD 2	1742	>	
- 3.	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	()	7				
87.5	Regist	rar	MARZRO	1000	Ac	1	1.					

		1 - For State Registrar	State of Ma	aryland / Dep		Health and N	Mental Hyg	•	0000
		1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat Month	h Day Yea	3. Time of Death
Physic /Medi Examir	cal	Earl Thomas Simps			4b. City, Town,	or Location of Death	3	23 200 4c. County of De	6 3:35 A M
LAGIIII	iei	307D E. Market St			Snow	Hi11		Worces	ter
Funeral				(In yrs. last birthda)	/) If Under 1 Year Months Days		8. Date of Birth	0.5	Birthplace (State or Foreign Country)
Director		215-52-2659 Usual Residence of Decedent	1 ∑ XM 2 ☐ F	56 Yrs.	Months Days	Hours Mill.	(Month, Day, 10/20/1	949	MD
deeth with the Maryland rms 23s or 28s-f show r must be notified at	ō	MD Worce	star	10c. City, Town or I					10d. Inside City Limits 1 X Yes 2 No
the 28a	Directo	10e. Street and Number	5001	SHOW HIL	10f. Zip Code	-	10	Og. Citizen of What	Country?
3s of	0	307D E. Market St			218	63		USA	
deett	Funerai	11. Marital Status	12. Was Decedent 8	Ever in U.S. 13		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	14. Race - Ar	merican Indian,
ğ 🚆 💆	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ Armed Forces? If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🛣 No		Hican, etc.)	Specify:	hite, etc. White
od within 72 hours af giene. ar than "natural", or the Medical Exam	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dec	edent's Usual Occu	pation during most of work ed)	king	16b. Kind of Busine	ss/Industry
within 72 ene. then "na	m d	Elementary/Secondary (0-12)	Cotlege (1-4or 5	+)	ic Teache			T 3	
Hygie Dr. Hygie		17. Father's Name (First, Middle, Las		Musi	ic reache	T	ne (First, Middle, N	Educati Maiden Sumame)	on
d be antal ked o	To Be	Earl Irwin Simpso	n			Dora B			
ic, Marylation I and 2 should be file I Health and Mental Hy Itam 27 is marked othe other traumatic event,	-	19a. tnformant's Name/Relationship		19b. Mai	ling Address (Stree	at and Number or Ru		City or Town, State	e, Zip Code)
		Janet Simpson		3071	E. Mark	et St., Si	now Hill.	MD 2186	3
of He rother		20a. Method of Disposition		20b. Place of Disposemetery, cr	oosition (Name of ematory or other pla	ace)		20c. Location - City	
permit. Pages 1 ar Department of Hea Important: If Itam: any injury or other page.		1 ☑ Burial 2 ☐ Cremation 3 (4 ☐ Donation 5 ☐ Other (Speci				hyard 3/2	7/2006	Snow Hill	. MD
permit. Pag Department Important: I any injury o		21. Signatule of Fune a Service Lice	nsee		22. Name and Addr			ige Funera	
D ed de de de de de de de de de de de de		18 Luc/	Bulace		108 Will:	iam St.,			
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nolications that caused one cause on each lin	the death. Do not e	nter the mode of dy	ing, such as cardiac	or respiratory arre	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	(/ .	uphome					Onset and Death
/Medical		resulting in death)	Due to (or as	a consequence of):					90025
Examiner	_	Sequentially list conditions,	b						
pe is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
be executed icien and burial-transit	хаш	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
ate be executed hysicien and he burial-transit	calE		040 (0) 43	a consequence or).					
g physias the			d						
death certificate a strenging phy	by Physician/Med	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of o	letiveo
Beath cert attendin	ciar	in the past 12 months?		2 Fetal death 3	☐Ectopic pregnand ☐ Other (specify)	су		Month Month	Day Year
the dy the achee	ysi	9 Unknown	9☐ Unknown						
det de	Y P	Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying cause g	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ician: The law requires t certificate hes been signe rector, page 2 should be	be d						1 ☐ Ye	s 2 12 No 3 🗆	Probably 4 Unknown
iaw re es bee	Completed						24a. Was ar	a 24b. Were	autopsy findings available o completion of cause of
sician: The law certificate hes t irector, page 2 s	E						autops:	ned? death	to completion of cause of es 2 No
iffica tor, p	a	25. Was case reterred to medicat	<u> </u>			26. Place of Dea	1 ☐ Yes 2 th (Check only one		es 2 No
	To B	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpati	ent 3 DOA	ther: 4 Nursing H			pecify)
ig Phy ter this heral d		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inju	ury at	28d. Describe ho		
Attanding or death. actor: After by the fune	atic	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	on	, ,,,,,,		Yes 2 No			
I or Attanding after death. Director: After din by the fune	Certification:	3 Suicide 6 Could not t 4 Homicide determined		iry - At home, farm, s :. (Specify)	treet, factory, office		28f. Location (Str City or Town	eet and Number or , State)	Rural Route Number,
na Hospital or Attanding Ph no 24 hours after death. The Funeral Director: After the pietely filled in by the funeral	Medicai C	29a. Certifier 1 Certifying P (Check only one) 2 Madical Exa	hysician: To the best of minar: On the basis of and manner sta	examination and/or	ath occurred at the tinvestigation, in my	ime, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licen	se number	29	d. Date signed (Mo	onth, Dey, Year)
		C gant	- Gill J	1 14.3	200	2632 53		3-24-	06
		30. Name and address of person who	completed cause of di	eath (Item 23a) (Type	e, Print)	163253			
TH 6		C. Exuest			Shea	Hill,	40 21	863	
Sta		31. Date filed (Month, Day, Year)	32. Pogistra	r's Signature					

			For State Registrar	State of	Maryland		artment of F		Mental Hyg	iene 2006	0839
	Physici		1. Decedent's Name (First, Middle, L	ast)					2. Date of Deat		3. Time of Death
	Physici /Medio		Bertha Lor	etta	Steven	S			March 2		4:20 p.m.
	Examir	er	4a. Facility Name (If not institution, g		,		4b. City, Town, or	r Location of Dea	ith	4c. County of Deat	h
		1	St. Thomas More					ttsvill		Prince G	
	Funeral Director		5. Social Security Number 6. 577–74–0883	Sex 1 ☐ M 2 🂢 F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	n. (Month, Day,	Year) Co	nplace (State or Foreign untry)
Ь.	890		Usual Residence of Decedent		80				March 5,	1926 Mar	yland
	yland		10a. State 10b. County		10c. City, 1	Town or Lo	ocation				10d. Inside City Limits
	e Maria	cto	Maryland Pri	nce Georg	ges		C1:	inton			1 ☐ Yes 2 No
	ी 0 28	Director	10e. Street and Number				10f. Zip Code		10	0g. Citízen of What Co	untry?
	ath w		9303 Pella Plac					735		United St	
	ltem Item	Funeral	11. Marital Status 1 ★ Never Married 2 Married	Armed For		13.	Was Decedent of H If Yes, specify Cuba	íspanic Origin? (ın, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, White	
336	irs af	by F	3 Widowed 4 Divorced	1 🗌 Yes If Yes, Give Year or Da	0		1 ☐ Yes 2X No	Specify:		Specify: B1	ack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Mcdical Examirer must be notified at	ted	15. Decedent's		1	16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/	Industry
215	thin 72 ho e. an "natu	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	kind of work done of DO NOT use retired	during most of wi 1)	orking		
2	D 20 5	Co	10				Housekeep			Houseke	eping
and	9 7 5 S	Be	17. Father's Name (First, Middle, Las	st)					ame (First, Middle, M	,	
Maryland	should be ind Mental is marked o	٦	Richard Stevens 19a. Informant's Name/Relationship	(Time Seint)		40h 14-75	- Add (0)		L. Carte		
Ma	2 8 8	1	Walter Stevens							City or Town, State, Z	· · · · · · · · · · · · · · · · · · ·
ē,	t and Health tem 27 other to	133	20a. Method of Disposition	/ 3011	20b. Plac		sition (Name of natory or other place			on, Maryla 20c. Location - City or	
E C	Pages nent of int: If it iry or o	- 9	1 XBurial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spec		JIAIO				8_2006 H	ollywood,	Maruland
Baltimore,	permit. Pages Department of the Important: If ite any injury or o	1	21. Signature of Fuperal Service Lic		100.					Funeral Ho	
m	Ped La	11 13	Edward N. Brinst	ield, Jr	. M000						20650-0279
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ca y one cause on ea	aused the death.	Do not ent	er the mode of dyin	g, such as cardi	ac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	, A27.	enoso	der	ote C	andu	Vascular	(Distease	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):				700	pag.
		er	Sequentially list conditions,	b. Due to fr	or as a consecuen	ea off					
	uted 1 ansit	min	cause. Enter Underlying Cause (Disease or injury	2000							
ć	exection and and rial-tra	Examin	that initiated events resulting in death) Last	Due to (c	or as a consequer	nce of):					
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai		d							
9	artifica ing ph e as tl	Med	IF FEMALE:								
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1☐Live bi	come of pregnancy rth 2 Fetal de	ath 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
0.	it the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of deat wn	h 5□	Other (specify)			Month	Day real
Δ.	that til ed by detac		Part II. Other significant conditions	contributing to de	ath but not resulting	ng in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	uires n sign ild be	d by	Cerebral 1	4 fa	NOS	on	, ,		1 ☐ Ye		obably 4 Unknown
00	w requir s been si should	ompleted	NV DO WOOD Y	ract	INFE		on. r	- D CALLO	Was ar	24b. Were au	topsy findings available
	ق ب ق	шо	Dunkater	My	11540	1 1			autopsy	y prior to death?	ompletion of cause of
Vital	ician: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?		VU IV			26. Place of De	1 ☐ Yes 2 eath (Check only one		212 140
of V	ys is	10	1 Yes 2 No	Hospital: 1 🗆 Ir	npatient 2 ER	VOutpatier	it 3□ DOA Oth	er: 4 Kursing	Home 5 ☐ Reside	nce 6 Other (Spec	eity)
		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date o (Month	of Injury 28 h, Day Year)	Bb. Time of Injury	Worl	K?	28d. Describe ho	w injury occurred	
Sic	or Attending after death, Director: Afte in by the fune	icat	2 Accident Investigati 3 Suicide 6 Could not	be -	- 61-1 A. 6			Yes 2 □No	000 1 (0)		
Division	after death after death Director: , d in by the f	Certification:	4 ☐ Homicide determine	d 286. Place buildin	of Injury - At home ng, etc. (Specify)	e, rarm, str	eet, factory, office		City or Town	reet and Number or Ru , State)	ral Houte Number,
	Hospital		29a. Certifier 1 Certifying F	hysician: To the	best of my knowle	dge, death	occurred at the tin	ne, date and place	e, and due to the ca	use(s) and manner as	stated.
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Expone)	aminer: On the ba and mann	isis of examination	and/or in	vestigation, in my o	pinion, death occ	curred at the time, da	ite and place, and due	to the cause(s)
	To the within comp	Ž	29b. Signature and title of certifier	. 1		,(29c. Licenso			d. Date signed (Month	
)	100		Mull	enle	elox	-Cu	1) 2	0185	2 1	1ARCH 2	4 2006
Ć	× a. ,		30. Name and address of person wh	o completed cause	of death (Item 23	За) (Туре,	Print)	20 . 1	00	4-4	1/4 My 2024
	<u> </u>		31. Date filed (Month, Day, Year)	10/60	egistrar's Signature	120	SCYUE	ensb	ong ca	1741BU	HEND A
	Sta Registr			06	, January Congression	Local	K)				

State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Calvin Pontious Shafer Jr. March 21, 2006 7:55 A^{M} /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 8. Date of Birth (Month, Day, Yea Frederick Memorial Hospital
al Security Number 6. Sex 7. Age (In yrs. last birthday) Frederick
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Min. Year) Months Hours 1**X** M 2□ F 79 215-20-8533 Yrs. 1926 MD Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 28a-f shov 1 Yes 2000 Frederick Middletown Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3635 Bussard Rd. 21769 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 0 / 14. Race - American Indian, 11. Marital Status 1 Tyes 2 No 1944 Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 1946 Completed by White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) carpenter construction d 2 should be filed v h and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvin P. Shafer Sr. Lora Beachley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if Item 27 is n sny injury or other traun once. Betty Shafer (Wife) 3635 Bussard Rd., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Reformed Cemetery 3/25/06 Middletown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Donald B. Thompson Funeral Home
31 E. Main St., Middletown, MD 21769
Approximate 21. Signature of Funeral Service Lice Mi Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Betw Onset and Death Immediate Cause (Final of bile ancer **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. lan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Day Physici 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 Tyes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No page Co Tox 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death | Check only one examiner? Hospital: Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1. Natural Injury 1 ☐ Yes 2 ☐ No death 2 Accident the within 24 hours after deatl To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the heat of my knowledge, death occurred at the time, dath and stone, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0968 06 arva 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUSTEN MURRICK MID 6010 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** March 21, 2006 3:55 P M Florence Siegel /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 413 Ridgepoint Place #16 Gaithersburg Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Director Yrs. 411-44-5183 July 20, 1933 New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, it will medical Examiner and the published at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 413 Ridgepoint Place #16 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl Farb Rose Fink 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debrah W. Miller/daughter 18325 Dutchess Drive Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 24, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2006 Beltsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myo cardie **Physician** /Medical Due to (or a a consequence of): Examiner onnou Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 3[] DOA After thi 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 0035859 3/22/2006 D 50/ N Frederick AVE 2087 of death (Item 23a) (Type, Print) 31. Date filed (Month) 32. Pagistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			For	Plea					d / Dep	artme	ent of	Health	and M	l Copies ental Hy		Legible.	1084	2
		· ·	1 - State Registrar						Ce	rtifica	ate of	Death	1		Reg. No	.000	10041	-
н	Physic	an	Decedent's Name	e (First, Midd	fle, Last)									2. Date of D Month	Da			١
	/Medi		Mary F							1, 0	-			Mar.	12,		9:12 p	М
	Examir	ıer	4a. Facility Name (/ Kris-Le		-					40. Ci	ry, Town,	or Location Sever		rk	40	County of De	Arundel	
	Funeral		5. Social Security N		6. Sex	Ja DIV		yrs. la	st birthday	If Und	der 1 Yea		r 24 Hrs.	8. Date of B	irth			ia
	Funeral Director		217-07-		10	M 2[X F		93	Yrs.	Month	s Day	s Hours	Min.	Oct. 1	ay, Year) 4 , 1	912	irthplace (State or Fore Country) PA	3
	pu ,		Usual Residence of	Decedent			110	n Cib.	Town and								Tan the same of	
	aryia ahov	7	10a. State MD	10b. County Anne	•	labr	10	c. City,	, Town or L		rna	Park					10d. Inside City Lim	
	the M	ect	10e. Street and Nur								Zip Code				100 Ci	tizen of What (_
	With With	급								101.					Tog. Ci		·	
	leath ne 23	era	831 Rite	citte n		2. Was Dec	edent Ever	r in U.S	6. 13.	Was De		146 Hispanic O	rigin? (Spe	cify Yes or N Rican, etc.)	10-		SA nerican Indian,	_
9	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f show other treumstic event, the Medical Examinar must be notified at	by Funeral Director	1 Never Marr	ied 2 Ma	rried	Armed Fo	2 🔀 No			tf Yes, s				Rican, etc.)		Black, Wh	white	
8	rail,		3 🛛 Widowed	4 Divorce	d	If Yes, Gi Year or C	oates:			1 L. Yes	265 N	o Specify	<i>'</i> :			Specify:	WIII CE	
5	72 h netu	ete	(Spec	15. Deceder ify only highe	nt's Educa est <i>grad</i> e	ation completed)			16a. Dece (Give	dent's U	sual Occ work don	upation e during mo red)	st of workir	ng	16b. K	and of Busines	s/Industry	
21215-0036	within lene. then "	Completed	Elementary/Seco	ndary (0-12) 12		Coltege (1-4or 5+)					Assis			וומ	ied Ch	emical Corp	_
	Hygie Hygie other I		17. Father's Name		. Last)					<u>xccu</u>	-1 vC			(First, Middle			enitear corp	٠.
Maryland	2 should be i and Mental i is marked of reumatic eve	o Be	Nichol										y Suj		0, 1112.00	, , , , , , , , , , , , , , , , , , , ,		
2	Shoul nd Ma	ဥ	19a. Informant's N			e, Print)			19b. Mail	ing Addre	ss (Stre				ber, City	or Town, State	Zip Code)	_
E	nd 2 lith au 27 is r freu		France				nter							Baldwir				
ē,	s 1 and 2 if Health item 27 i		20a. Method of Dis	position			2	20b. Pla	ace of Disp	osition (f	lame of	1	D	ate	T	ocation - City	or Town, State	_
Ę	Page net country or		1 XBurial 2 4 ☐ Donation			moval from	State		red He					2006		undalk	, MD	
Baltimore,	permit. Pages Depertment of I Important: if its any injury or of		21. Signature of Fu	eral Service	License	2. 1	//		3	3 Name	and Ado	rees of Faci			verna	Park	Funeral Hor	ne
\(\Pi \)	89 E 8 8		Ah	emus	12	HI	lin			195	Gov.	Ritch	ie Hw	vy, Sev	verna	Park,	MD 21146	
			23a. Part1. Enter t shock, or hea	he disease, d rt failure. Lis	or complications	ations that	caused the each line.	death.	. Do not en	ter the m	ode of d	ying, such a	s cardiac o	r respiratory	arrest,		Approximate Interval Between	
1	Physician		Immediate Cause disease or condition	(Final	а		Conge	est:	ive He	art	Fai	lure					Onset and Death	
	/Medical Examiner		resulting in death)			Due to	(or as a co	nsequ	ence of):									
-		_	Sequentially list co	nditions.	b.	Due to	(or as a co		Aortic	Ste	enos:	lS						_
	ted	nlner	Cause (Disease or	injury	₹	Due to	(01 as a 00	ирестк	ence or):									
	executed in and ial-transit	Examin	that initiated events resulting in death)	s Last	c.	Due to	(or as a co	onsequ	ence ol):									_
92	sician buria																	
6876(eath certificate be ettending physicia for use as the bur	edk			u.													
Вох	h cert endin use	M/U	IF FEMALE: 23b. Was deceden		23	c. If yes, ou	tcome of p			⊒Ectopic						23d. Date of d	elivery	
	0 0	Completed by Physician/Medical	in the past 12	ŽNo			nant at time			Other						Month	Day Year	
P.0	that the ed by th detache	Phy	9 Unknown															_
	res th iigned be d	by	Part II. Other signif								g cause (given in Part	I.				to the cause of death?	
ord	requires een sign nould be	ted	CILOII	ic Obs	LLUC	rive i	Pullio	lat	y DIS	ease				11	Yes 2	1 No 3 [X	Probably 4 □Unkno	wr
ec	a law asb b 2 st	nple												24a. Wa aut	opsy	prior t	autopsy findings availa completion of cause	ble
of Vital Records,	sicien: The law certificete has l irector, pege 2 s	S													formed? 2XNo	death		
Vita	ding Physician: h. After this certific funeral director,	Be	25. Was case refer examiner?			spital:							e of Death	(Check only	one)			_
o	Phys this al dir	To	1 Yes 2 2		110	1 🗆	Inpatient		28b. Time		DOA					6 □Other (Sp	pecify)	
	E E	tlon	1 X Natural	5 Pendi	ing tigation	(Mor	of Injury oth, Day Ye	ear)	Injury	M	28c. In W	ork? □Yes 2[28d. Describe	a now inju	iry occurred		
Division	deatl ctor: y the	lica	2 Accident 3 Suicide	6 Could	d not be	28e Plac	e of Injury	- At hor	me, farm, s					28f Location	(Street a	nd Number or	Rural Route Number,	
Σ	after Dire	Certification:	4 Homicide	deten	mined	buito	ling, etc. (S	Specify)		, 01110	-		City or To	own, State	в)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier	t⊠ Certify	ing Physi	ician: To th	e best of m	y knov	vledge, dea	th occurr	ed at the	time, date a	ind place, a	and due to the	e cause(s) and manner	as stated.	
	n 24 h n 24 h na Fu sietely	edical	(Check only one)	2 Medica	l Examin	er: On the t	basis of exa nner stated	aminati	ion and/or i	rvestigat	ion, in my	opinion, de	ath occurre	ed at the time	, date an	d place, and d	ue to the cause(s)	
	To ti withii To ti	Ž	29b. Signature and	title of certifi	ier /		1 0				29c. Lice	nse number			29d. Da	ite signed (Mo	nth, Day, Year)	_

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

UCINGA L. MUNGOF AVI DEFENSE t

31. Date filed (Month, Day, Year)

MAR 2 2 2006

MAR 2 2 2006

ORIGINAL

DODU2705

Annapolis mo 21401

700

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year STEELE, 23,250 .TAMES SR. 23 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ELKTON CECIL 155 APPLETON RD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1**X** M 2□ F 222-09-6745 82 Yrs. JUNE 18, 1923 WILMINGTON, DE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **NEW CASTLE NEW CASTLE** 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 9 GENE AVE 19720 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1944 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTUCTION IRON WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARGARET RITTENHOUSE (UNKNOWN) STEELE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES STEELE JR / SON 341 MISTY VALE DR MIDDLETOWN, DE 19709 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GRACELAWN MEMORIAL PARK MARCH 31, 2006 NEW CASTLE, DE 21. Signature of Funeral Service Licensee SPICER MULEIKEN FUNERAL HOMES INC 1000 N DUPONT HWY NEW CASTLE, DE 19720 M00840 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) COPD 1Rur S Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time ol death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case relerred to medical 26. Place of Death (Check only one) examiner dught4's Other: 4 Nursing Home 5 Residence 6 AOther (Specify) 1 ☐ Yes 30 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No. investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

physicien and s the burial-transit law requires that the death certificate be executed for use as Ö à م Division of Vital Records, certificate has After this or Attending death. within 24 hours after deatl To the Funerel Director: the filled in by To the Hospital

Physician

/Medical

Examiner

Funeral

Director

28a-1 ehow

Director

Funerai

δ

Completed

Be

other traumatic event, the Madical Exactiner must be notified at

permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "

Physician

/Medical

Examiner

Examiner

Physician/Medical

δ

Completed

Certification;

Medicai

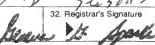
Maryland 21215-0036

Baltimore,

Registrar

30. Na/ne and address of person who completed cause of death (Item 23a) (Type, Print) ur/Las 31. Date filed (Month, Day, Year)

29b. Signature and Ittle of certifier



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year /Medical 06 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** S. last birthday) If Under 1 Year If Under 24 Hrs. MD Memorial land 7. Age (In yrs. last birth 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Months Hours Min 63 Director 233-68-1877 21/1942 8/ WV Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Illimportent: If item 27 is marked other than "natural", or items 23s or 28s-f show eny injury or other treumatic event, the Medical Examiner is ust be notified at 900s. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV Terra Alta 1X Yes 2 □ No Preston Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26764 PO Box 146 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XXNo Specify: Specify: White þ 3 ☐ Widowed 4 1 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Service Restaurant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Alletha Stahl Spahr Harland Dale Spahr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Towns Alta. WV 26764 19a. Informant's Name/Relationship (Type, Print) 306 Sanders Street, Terra Alta, WV Karen E. Helmick/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Terra Alta Cemetery /27/2006 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Terra Alta, W_V 21. Signature of Funeral Service Licenses Arthur H. Wright Funeral Home 105 Highland Ave., Terra Alta 26764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Dee Dee Dee to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 sf autopsy performed? Yes 25 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospitel or Attending Physicien: Be director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 R/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Hetural 2 Accident 5 Pending death. investigation 1 □ Yes 2 □ No after death Director; 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C completely filled i 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

31. Date filed (Month, Day, Year) MAR 2 9 2006

29b. Signature and title of certified



of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Maryla	•	irtment of tificate of		Mental Hy	giene Reg. No.20	06 10845
	Physici	ian	Decedent's Name (First, Middle, La Sally	ost) Dawn Smit	-h			2. Date of De Month	Day	Year 3. Time of Death
	/Medic Examir	cal	4a. Facility Name (If not institution, give		_11	4b. City, Town,	or Location of Deal	March	4c. County	006 1925 M
	Exami	161	PENINSULA REGIONAL	Medical Ce.	NSU/		SALISburg		11.	com 100
	Funeral Director			Sex 7. Age (In yr. 1□M 2⊠F 57	s. last birthday) Yrs.	If Under 1 Year Months Day		8. Date of Bit	th 1948	9. Birthplace (State or Foreign Country) Maryland
	deeth with the Maryland ome 23s or 28s-f show if must be notified at	ector	10a. State 10b. County Maryland Wicom:		City, Town or Loc Hebron				-	10d. Inside City Limits 1X Yes 2 □ No
	th with ti	Dir	10e. Street and Number 329 E. Lillian	n St.		10f. Zip Code 218	30		10g. Citizen of V	-
1.4×	hours after deeth v tural', or itema 23a	Completed by Funeral Director	11. Marital Status 1	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of Yes, specify Cu	Hispanic Origin? (§ ban, Mexican, Puer o Specify:	Specify Yes or No to Rican, etc.)		e - American Indian, k, White, etc.
Jun 1	n 72	npleted	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give I		e during most of wo ed)	rking	16b. Kind of Bu	
58	Hygien Hygien ther th nt. It.	Con	17. Father's Name (First, Middle, Last	<u> </u>	Medi	cal Ass		ma /First Middle	Opthamo	
Sally Sally Baltimore, Maryland 24	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if itam 27 is marked other than any injury or other traumatic avent, Itam ADEs.	To Be	Samuel Gibson	Smith			Dorot	hy anne	Graham	
, Mai	and 2 st ealth and m 27 is n		JoAnne Elizabeth	n Anderson/sis	ster 3	29 E. L	illian St	., Hebro	er, City or Town, on, MD 2]	State, Zip Code) L830
more	Pages 1 nent of H int: If ital		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Place of Dispos cemetery, crem alisbury	natory or other p	·	Date 2/06		City or Town, State
Balti	permit. Departmimporta		Horro M. Co	nsee	22	Horizond Add		Home Pr	ofession	nal Association
0	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that caused the derone cause on each line. Due to (or as a cons	equence of	er the mode of d	ving, such as cardia	c or respirator y a	rrest,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	equence of):	Pailu	al			
8760,	sate be executed hysician and the buriel-transit	dical Examiner	Cause (Disease or injury that initlated events resulting in death) Last	c Due to (or as a consi	equence of):					
Box 6	The law requires that the deeth certifics to has been signed by the ettending proage 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	atal death 3 🗆	Ectopic pregnan Other (specify)			23d. Dat Mor	e of delivery hth Day Year
ords, P	w requires the been signed I should be det	ted by P	Part II. Other significant conditions	contributing to death but not re	esulting in the un	nderlying cause g	iven in Part I.		obacco use contr Yes 2 ☐ No	ibute to the cause of death? 3 Probably 4 Onknown
Division of Vital Records, P.O.	: The law r cete has be page 2 sh	Comple						24a. Was auto perfo 1 Yes	psy ormed?	Were autopsy findings available prior to completion of cause of leath? ☐ Yes 2☐ No
Vita	Physician: Th this certificete ral director, pag	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		C	thes	ath Check only		
ion of	fing After	atlon; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. inj	4 Nursing i		dence 6 Othe how injury occurr	
Divis	isi or Attandi s efter death is Diractor; A ed in by the f	Certification;	3 Suicide 6 Could not be determined		home, farm, stre cify)	eet, factory, office	•		Street and Number wn, State)	er or Rural Route Number,
	To the Hospital or Attend within 24 hours effer death To the Funeral Director; completely filled in by the	edical	29a. Certifier 1 Partition P (Check only one) 2 Medical Exa	hyaician. To the best of my k miner: On the basis of exami and manner stated.	nawledge dealf nation and/or inv	ossumed at the restigation, in my	time, date and place opinion, death occ	a, and due to the urred at the time,	edus.(s) and ma date and place, a	and due to the cause(s)
	within To the comp	Ž	29b. Signature and title of certifier	7 8 0	1		nse number			1 (Month, Day, Year)
	OB		30 Name and address	normalistad	00-10-	400	1-7 416	7	3/22	106
	1/2		30. Name and address of person who	, D.O. 100	E. CAN	1011 ST.	5.44/5	bun 1	no	
	Sta Registi		31. Date filed (Month, Day, Year)	2006 32. Registrar's Sig	nature #	nasti)				

				epartment of Health and M Certificate of Death	ental Hygier	1111h	10847
	Physici	20	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medi		William Isaac Thomas		3 1	8 2006	2:38 PM.
	Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Dorchester General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Cambridge		Dorcheste	
П	Funeral Director		400 AUG	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) 9. Birth	place (State or Foreign ntry)
	ס		Usual Residence of Decedent		March 26,	1926 Virg	inia
	rylan how		10a, State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	98-1-8	Director	Maryland Dorchester Cambrid	ge			1 ☐ Yes 2 ☐ No
	or 24	Dire	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cou	ntry?
	s 23e	rai		21613		USA	
	Itam Itam	Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Ves 2 ★ No	 Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F 	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
39	urs af	by	3 Widowed 4 Divorced If Yes, Give	1 ☐ Yes 2 🕱 No Specify:		Specify:	
Ö	within 72 hours after death with the Maryland ane. than "netural", or items 23a or 28e-f show ta Medical Examinar must be rotified at	ted	15. Decedent's Education 16a. I	Decedent's Usual Occupation	16b.	Kind of Business/Ir	ack idustry
215	thin 7	Completed	(Specify only highest grade completed) (Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of workin life. DO NOT use retired)	Fr	ed Robins	on
2	ed wi	Con	3 Fo	rk Lift Driver		rehouse	
nd	ital H d off	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Sumame)	
Z	d Men d Men narke	^L		Maggie S			
Maryland 21215-0036	d2sh nanc 7 Isn traun		1	Mailing Address (Street and Number or Rural			
D	1 and Health em 2			7 Camper Street, Cam Disposition (Name of Da	-	ryLand 21 Location - City or To	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or itams 23s or 28e-f show any injury or other traumatic event, the Madical Examinat must be notified at ODGs.		1 ■ Burial 2 □ Cremation 3 □ Removal from State	crematory or other place)	250.		
量	ortan ortan		'4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Cemetery 03-25- 22. Name and Address of Facility	-2006 Cam	bridje Ma	ryland
Ba	Dep m m g d g d g d g d g d g d g d g d g d g d		Day of Day of	Bennie Smith Fune: 524 Race Street,	ral Home	36 3	1 01610
			23a. Parti. Enter the disease, or complications that caused the death. Do no	t enter the mode of dying, such as cardiac or	respiratory arrest,	e,Marylan	Approximate
u	Ffrysi ci an :		sheck, or heart failure. List only one cause on each line. Immediate Cause (Final	a carlom fil	ure		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of		CUC		12 43
H	Examiner		Sequentially list conditions by Sente SM	ock			36 hrs
	D ==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1 - 1 -			1
	ecute and trans	Examiner	that initiated events c.				4 days
8760,	cate be executed physiclan and the burial-transit	E	Due to (or as a consequence of):			,
387	physic the	dicai	d				
9 X	eath certific attending p	/Me	IF FEMALE: 23b. Was deceded pregnancy 23c. If yes, outcome of pregnancy			and Data of deliver	
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23b. Was decedent pregnant in the past 12 months? 4 ☐ Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	Day Year
o.	that the death hed by the atter detached for u	hysi	9 Unknown				
ري ص	The law requires that the death certific is the been signed by the attending page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco	use contribute to the	ne cause of death?
rd	w require been sig should b	edt	small bowel obsmichen; h	115 hory of color	1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Unknown
Records,	law re as be 2 sho	Completed	cancer sickle cell hait:	hypertesion:	24a. Was an	24b. Were auto	psy findings available
_	sician: The law certificate has b irector, page 2 s	Com	high cholesterol renal fall	ine incorression	autopsy performed? 1 Yes 2 V	death?	mpletion of cause of
Vita	cian: artific actor,	Be (25. Was c ereferred to medical examiner?	26. Place of Death			
<u></u>	hysia this call dire	မ	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outp		e 5 🗆 Residence	6 □Other (Specify	<i>(</i>)
Division of	After I	iuo.	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Inju	iry Work?	3d. Describe how inj	ury occurred	
S	ottendi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	24 1		
<u>></u>	after Direction by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	i, street, factory, office	3f. Location (Street a City or Town, Sta	te)	I Houte Number,
_	spita nours neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, of	death occurred at the time, date and place, an	nd due to the cause/	s) and manner as si	ated
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	(Check only one) 2 Medical Examiner: On the basis of examination and/one) and manner stated.	or investigation, in my opinion, death occurred	at the time, date a	nd place, and due to	the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month,	Day, Year)
			▶ 449elentt.MD	D0059939] 3	3/18 hone	2
	/		30. Name and address of person who completed cause of death (Item 23a) (T)	/pe, Print)		1 12000	Cambridge
	0		2221110tt, MD Dorchester	veneral Hospital	300 B	sum St	MD 21613
	Sta Registra	• .	31. Date filed (Month, Day Year) AR 2 1 2006 Registrar's Signature	book			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Kiyai Antwan Terri March 0511 Am 2006 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner University of Maryland
5. Social Security Number 6. Sex Center | birthday) If Under 1 Year Baltimore If Under 24 Hrs. 8. Date or Medical 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1XM 2□ F Director 2 2006 march maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo saltimore maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1528 West tay ette Street USA 21223 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 M Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant Infan of the end Mantal Hygie 27 is marked other treumatic event, if 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pegas 1 end 2 should be akei a 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 223 19a. Informant's Name/Relationship (Type, Print) fayette Street Baltomore mb mother Depertment of Heelth mportant: If item 27 1528 West Riles -aKeia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 SCremetion 3 ☐ Removal from State University of Martines 3 06 of maryland Baltimore maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Signature of Baltimore, mb Overne Street 22 Sough University 51501 maryland medical 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Prematurity **Examiner** Due to (or as a consequence of) Physician/Medical Examiner Attending Physicien: The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 2 Be Completed 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of deeth? 2200 1 🗌 Yes 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 24 hours To the Hospital within 24 hours To the Funerel 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 16 Rev 6/95

29b. Signature and title of certifier

Jelinek

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

2006

MD

So Greene

egistrer's Signatur

29c. License number

Baltimore

29d. Date signed (Month, Day, Year)

March 02

Amo	end	ed,29c,	30	State of Mary 1- State of Mary 93/27/00, SBB	•	artment of F rtificate of			ene 1. No. 0 0 6	10849
4		Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last) DOROTHY S. VOSHELL 4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	2. Date of Death Month	Day Yea 23 200 4c. County of Do	6 0232 M
	2.0	Funeral Director		5. Social Security Number 217-80-2415 Memorial Hospital 6. Sex 1 M 2 F 7. Age (In	n yrs. last birthday) 92 Yrs.	Ea	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y JUNE 9 1	Telb	
			ctor	Usual Residence of Decedent	Oc. City, Town or Lo	ocation STON		JUNE 7 1	J13 11	10d. Inside City Limits 1 ☐ Yes 2 No
		leath with the ns 23a or 28 must be not	Funeral Director	10e. Street and Number 10282 THREE BRIDGE BRANCH I 11. Marital Status 12. Was Decedent Ever		10f. Zip Code 216			USA	Country?
/	90036	hours after death with tural", or items 23a or al Exacting mast be	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes - SM No 1 ☐ Yes - SN No 1 ☐ Yes - Sive Year or Dates:		1 ☐ Yes 2 X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:		Black, W	hite, etc. WHITE
Vashel	121215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f ehow ent, the Madical Examiner must be notiling at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 0	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work d)	ring	OWN F	,
S.V	Maryland	ed at a s	To Be	17. Father's Name (First, Middle, Last) WALTER STINSON 19a. Informant's Name/Relationship (Type, Print)	19b. Mailii	ng Address (Street	ANN	e (First, Middle, Ma IE VESTY Tal Route Number, C	,	ə, Zip Code)
J. VANE VUSHELL/SUN 10791 CHAFEL RUAD, CORDOVA, FID 21029										
Š	Baltimore,	permit. Pages: Depertment of F Important: If its any injury or of		21. Signature of Funeral Service Licensee Oseph M. Ostrony C. f	GREENMOUN					L HOME PA
	A STATE OF THE STA	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	stive H	1 0	ng, such as cardiac	or respiratory arrest		Approximate Interval Between Onset and Death
	760,	ate be executed with the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	onsequence of):	1	ease			hours years
	O. Box 68760,	sath certifica ettending ph for use as th	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 12 10	pregnancy	□Ectopic pregnancy	,		23d. Date of o	
	ords, P.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but no hypercholes tecolemia.	ot resulting in the u	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 □Unknown
	tal Rec	ician: The law octificate has booter, page 2 sh	e Completed	Diabeles 25. Was case referred to medical		71	26. Bleen of Death		d2 death	autopsy findings available o completion of cause of ? es 2 \sum No
	Division of Vital Records, P.O.	ding Physician: The I h. After this certificate ha funeral director, page	lon: To Be	examiner? 1 Yes 2 100 Hospital: 1 Inpatient 27. Manner of Death 1 Natural 5 Pending (Month, Day Ye)	2 (EFVOutpatien 28b. Time of Injury	f 28c. Injur Wor	er: 4 Nursing Hoyat y at k?	th (Check only one) ome 5 Residence 28d. Describe how		pecify)
	Division	ital or Attendi rs after death. al Director: A led in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury-building, etc. (S	- At home, farm, str Specify)		Yes 2 □No	28f. Location (Stree City or Town, S	et and Number or State)	Rural Route Number,
		To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the ft	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of m 2 Medical Exeminer: On the basis of examiner stated. 29b. Signature and title of certifier	amination and/or in	vestigation, in my o	pinion, death occur e number	red at the time, date	se(s) and manner and place, and o	lue to the cause(s)
		- > - 0		Rossward From 30, Name and address of person who completed cause of death		Print)		Ran O	3-23-	•
		Sta Registr		R Buyeyne K latsa beede mid 31. Date filed (Month, Day, Year) MAR 2 7 2005	555 C	Ynwood	Drive	Eastm 1	MD	

				State of Ma							-		•	10051	`
			1 - For State Registrar			Cer	tificate	of L	Death			Reg. No	UUb	10850	-
	Physici	an	Decedent's Name (First, Middle, Las	t)							2. Date of De	aath Da	y Year	3. Time of Death	
	/Medi		WILLIE MAE WILSON								3 -19			7:20 A	M
	Examir	ier	4a. Facility Name (If not institution, give	,					Location of	Death		1	County of Dear		
	Funeral		PRINCE GEORGES HOS 5. Social Security Number 6. Se		e (In yrs. last		If Under 1	Year	If Under 24	4 Hrs.	8. Date of Bir	rth .	RINCE GE		ion
	Director			□M 2(X)F	92	Yrs.		Days	Hours	Min.	(Month, Da 8-31-1	ay, Year)	McCC	chplace (State or Fore puntry) RMICK, SC	<i>y</i> ,,
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-f show int, the Medical Examinar must be notified at		10a. State 10b. County		10c. City, T									10d. Inside City Limit	ts
	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Items 23s or 28s-f show event, the Medical Examinat must be notified at	Director	DC		WASH	INGTO	N							1X Yes 2 □ N	10
	or 28	Oire	10e. Street and Number				10f. Zip 0	Code				10g. Cit	izen of What Co	ountry?	
	ath w		2700 JASPER ST SE				2002					USA			
	er de Items	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13. V	Vas Decede Yes, specif	ent of His fy Cubar	spanic Origi , Mexican,	n? (Spec Puerto R	ify Yes or No ican, etc.)	D-	 Race - Ame Black, Whit 		
36	I', or	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	10	1	☐ Yes 2	X) No	Specify:				Specify: BLA	CK	
21215-0036	2 hou		15. Decedent's Ed	ucation	1	6a. Deced	ent's Usual	Occupa	tion			16b. K	ind of Business	Industry	
212	thin 7	ple	(Specify only highest grad	de completed) College (1-4or 5	+)	(Give H	kind of work OO NOT use	done di retired)	uring most o	of working	9			,	
7	ed wii	Completed	12TH			JRSIN	G ASS					PRIV			
	e d fa	Be	17. Father's Name (First, Middle, Last)								First, Middle		Sumame)		
<u>8</u>	ould J Mer narke	J.	JOSEPHUS WILSON	0/-4							BINSON				
, Maryland	s 1 and 2 should if Health and Men tem 27 is marke other traumatic		19a. Informant's Name/Relationship (T RICHARD R. JOHNSOI										or Town, State, 2		
Baitimore,	0 0		20a. Mathod of Disposition 14 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,		RESUE	of Dispos Hery, crem RRECT	sition (Name natory or oth ION C	e of Terplace EMET	ERY 3	Da /27/	te 2006		ocation - City or ITON, MD		
<u>a</u>	permit. Pag Depertment Important; I any injury o		21. Signature of Funeral Service Licens	500	1 1	22.	Name and	Address	of Facility	MARS	HALL'S	FUN	ERAL HO	ME	
n	90 E = 9		Muak-	1 nous	nal	1					ITLAND		20746		
	Physician		23a. Part. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	lications that caused ne cause on each lin SEPSIS	the death. De.	o not ente	er the mode	of dying	, such as ca	ardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to (or as a	1 consequenc	ce of):									
	Examiner	_	Sequentially list conditions,	b											
	tuted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that indiated events	Due to (or as a	i consequen	ce of):									
/60,	ite be executed sysicien and se burial-transit	cal Exa	resulting in death) Last	Due to (or as a	consequenc	ce of):									
189	a : a			d											
XOR	leath certificat attending phy I for use as th	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy								23d. Date of del	verv	
	that the death hed by the atten detached for u	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ØNo 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic preg Other (spec						Month	Day Year	
ري ح	requires that een signed b nould be deta	by PI	Part II. Other significant conditions co	ntributing to death bu	t not resulting	g in the un	derlying cau	use giver	n in Part I.		23e. Did t	obacco u	se contribute to	the cause of death?	
ğ	w require been sig should b	edt	MALNUTRITION					_			10	Yes 2	□No 3□Pr	obably 4 Unknow	'n
Hecord	e law requ has been je 2 shoule	Completed	SACRAL ULCER								24a. Was		24b. Were au	topsy findings availab	le
-	The ate h page	E O									autor perfo	rmed?	death?	completion of cause of 2 No	
VIIai	ysician: Th	Be (25. Was case referred to medical examiner?						26. Place of	f Death	Check only				
5	Physician: this certific rat director,	은	1 142 5 E 140	lospital: 1 Timpatier			3□ DOA		4 🗀 14012	ing Home	9 5 □ Resi	dence	6 □Other (Spec	cify)	
		lo i	27. Mapner of Death 1 △Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28t	D. Time of Injury		c. Injury			d. Describe	how injur	y occurred		
DIVISION	ten for: the	ertification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	n/ - At home	farm etro	M ot factory		es 2 □No		f Location /	Stroot an	d Number of D	ral Route Number,	
\leq	or lifte		4 Homicide determined	building, etc	(Specify)	iaiii, stie	er, ractory, r	onice		20	City or To	wn, State)	rai rioute Number,	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner state	examination	lge, death and/or inve	occurred at estigation, in	t the time	, date and p nion, death	place, an occurred	d due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier				29c. I	License	number			29d. Dat	e signed (Montt	n, Day, Year)	
•			Par	Eu-	- n	1.0.	יחת	0576	36			3/19	/2006		
0-	(2)		30. Name and address of person who co	ompleted cause of de			DO	5570	J-0			J/ 1/	, _000		
			PATRICIA EBEN 300				RLY, I	MD 2	0785						
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 2 3 2006	32. Registra	r's Signat ure	hour	E)								

			1 - For State Registrar	State of Mar				leaith a Death	ind M		giene Reg. No.	06	10851
	Dhuoisi		1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		RITA MARGARET WAR			T				March 2		2006	10:45 a ^M
1	Examir	er	4a. Facility Name (If not institution, give:					Location of	f Death			County of Dea	
	stylling.		Hillhaven Nursing 5. Social Security Number 6. Secu		n yrs. last birthday,		elphi er i Year	If Under 2	24 Hrs.	8 Date of Birt			eorge's thplace (State or Foreign
255	Funeral Director			M 2⊠F 9	Van		Days	Hours	Min	8. Date of Birt. (Month, Day May 23,	Year)	C	hington, DC
400	D		Usual Residence of Decedent							11ay 25,	171	J Was	ningcon, DC
	arylar ehow d.at	_	10a. State 10b. County		Oc. City, Town or L	ocation							10d. Inside City Limits
	18a-f	ecto	Maryland Prince (George's	Adelphi	1							1 ☑ Yes 2 ☐ No
	with the	Dir	10e. Street and Number 3210 Powder Mill	Pond			p Code					en of What Co	ountry?
	death with the Maryland ms 23a or 28a-f ehow Γπικαί be πουίθεί at	Funeral Director	, , , , , , , , , , , , , , , , , , ,	12. Was Decedent Eve	er in U.S. 13		0783	ispanic Orio	un? (Sne	ocify Yes or No-		S.A. 4. Race - Ame	arican Indian
(0	riten	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No					, Puerto	cify Yes or No- Rican, etc.)	,	Black, Whit	
8	rel', o	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2X No	Specify:				Specify:	White
Maryland 21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usu	al Occupa	ation during most	of workii	ng	16b. Kin	d of Business	/Industry
121	within ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+))			0-		1 70 1
7	Hygie ther I	CO	12 17. Father's Name (First, Middle, Last)			Baker		18 Mother	r's Name	(First, Middle,			l Bakery
an	d be ental ked o	To Be	Matthew Sweeney							Fowler		30	
ary A	shoul nd Ma mari	Ĕ	19a. Informant's Name/Relationship (Ty	pe, <i>Print)</i>	19b. Maili	ng Addres	s (Street a			/ Route Numbe	r, City or	Town, State,	Zip Code)
Ž	alth a		Richard J. Warner	Jr Son	2015	Pea	body	Stree	et. I	Ivattsv	ille:	. Marvl	and 20782
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "naturel", or Items 23a or 28a-f show any fujury or other traumatic event, If a Mudical Examinating the routiled at ance.		20a. Method of Disposition		20b. Place of Dispo	sition (Na	me of		D	ate		ation - City or	
Ē	Pagement ment		1 ⊠ Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	Fort Line				3/25	/2006	Bren	ntwood,	Maryland
3alt	eparti eparti nport ny inj		21. Signatura of Funeral Service License	90	2:	2. Name a	nd Addres	s of Facility	Gas	sch's F	unera	al Home	e, P.A.
ш	40 = 9 a		Jun L. Well			4739	Balt:	imore	Avei	nue, Hy	atts		MD 20781
П			23a. Pagt1. Enter the disease, or complishock, or heart failure. List only or	dations that caused the cause on each line.	e death. Do not en	ter the mod	de of dying	g, such as o	cardiac o	r respiratory ari	rest,		Approximate Interval Between Onset and Death
W.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ia Cardia	ıc							5 minutes
**.	Examiner			Coronar	onsequence of): y Heart I	daaa							
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c		riseas	se						20 years
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Diabeti	s Mellitu	ıs							30 years
ó	an an urial-tr	Exa	resulting in death) Last	Due to (or as a c									30) 6418
8760,	cate be executed physician and the burial-transit	lical		Hyperte	nsive Car	diova	ascu1	ar Di	seas	e			30 years
Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of		7=					23	3d. Date of de	ivery
о В	le deatl	sicia	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		Ectopic p Other (sp						Month	Day Year
P.0.	that the		Part II. Other significant conditions con	tributing to death but n	ot resulting in the u	nderlying e	cause dive	n in Part I	7	23e. Did to	bacco us	e contribute to	the cause of death?
ds,	uires tha signed Id be del	d by	Chronic Urinary				3						obably 4 Unknown
CO	w require been si should	lete	Gangrene Foot							24a. Was a			itopsy findings available
Re	he la e has age 2	Completed								autop: perfor	sy med?	prior to death?	completion of cause of
ta	icien: Th certificate ector, pag	0	Anemia, Renal Ins	sufficency				26 Place	of Death	1 ☐ Yes	5 5 1 1 mm	1 🗌 Yes	2 □ No
>	nysici nis cen direc	To B	examiner? 1 ☐ Yes 2 📉 No	ospital:	2 ER/Outpatier	nt 3 🗆 D0	OA Othe	ur-		ne 5 Resid	-4	Other (Spe	city)
0	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yo	28b. Time o	f 2	28c. Injury Work	at ?	2	8d. Describe h	ow injury	occurred	
Sio	Attending Physicien: The rideath. ector: After this certificate hiby the funeral director, page	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 🗆 1	′es 2 □N	lo				
Division of Vital Records,	I or Attendation of the organization of the or	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (3	· At home, farm, str Specify)	eet, factor	y, office		2	8f. Location (S City or Tow	treet and n. State)	Number or Ru	ural Route Number,
_	To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by		29a. Certifier 1 X Certifying Phys	ician: To the best of m	ny kinowladgo, death	n decumed	at the ten	e, data and	plane, a	nd dua to this e	auco(c) a	ind manner ac	tital sõ.
	To the H within 24 To the Fi complete	Aedical	one) 2 Medical Examir	er: On the basis of ex and manner stated	amination and/or in	vestigation	ı, in my op	inion, death	h occurre	ed at the time, d	late and p	place, and due	to the cause(s)
	To Too	Σ	29b. Signature and title of certifier				c. License					signed (Mont	
^	1	1	- June	W			D178	43			marc	h 21,	2006
K_	· (t)		30. Name and address of person who co- Vivek C. Vadi, M				R102	Uses	++	411- 24	D 00	700 01	1.6
	Sta	te	31. Date filed (Month, Day, Year)		edo Terr	ace,	שנטע	, пуа	LLSV	ттте, М	ע 20	/82 - 81	46
	Registr		MAD 2 3 2006	Plane	Signature								

NLM 06-01904 Theresa Whitmyer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

esa	WIII CIII	er	1 - For State Registrar	State of Maryland / [Department of Certificate of			ene g. No. 0 0 6	10852
	D		Decedent's Name (First, Middle, I	.ast)			2. Date of Death		3. Time of Death
	Physici /Medio		Theresa	Whitmyer			March	17,2006 Year	8:38 P M
	Examin		4a. Facility Name (If not institution, g		4b. City, Town,	or Location of Death		4c. County of Death	1
			Doctors Hospita	7	Lor	nham		Prince Ge	orges
	Funeral			Sex 7. Age (In yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birth	nplace (State or Foreign untry)
	Director		579-46-3060	1□ M 2ŪXF 71	Yrs. Months Days	Hours Min.	(Month, Day, June 1,		h Carolina
	9		Usual Residence of Decedent						
	how	_	10a. State 10b. County	10c. City, Tow	n or Location				10d. Inside City Limits
	e Ma	ç	Maryland Prince	George's	Upper Ma	arlboro			1∭Yes 2☐No
	라 28 라 28	ē	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cor	untry?
	15 wi	a C	3121 Py1es I	rive		20774		United	States
	dea dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer Black, White	ican Indian,
9	filed within 72 hours after death with the Maryland Hygiene. that than "naturel", or iteme 23a or 28a-f ehow int, the Medical Examinat must be notified at	臣	1 Never Married 2 Married		1 ☐ Yes 2 ☒ No		riloan, oto.)	A	frican
93	ours	5	3	Year or Dates:	10 103 224 110	эрвспу.		Specify:	merican
Maryland 21215-0036	72 h	Completed by	15. Decedent's (Specify only highest)		Decedent's Usual Occu (Give kind of work done	during most of work	ina 1	6b. Kind of Business/I	ndustry
21	thing.	효	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	ed)			
21	od wi	Ş		1	Hot	ısewife		Priva	te
P	a the file	Be (17. Father's Name (First, Middle, La	st)		18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
<u> a</u>	Vent Ment Ment Ment Ment Ment Ment Ment M	2	Leroy (raham			Blanche :	Parsons	
an	Sho m m		19a. Informant's Name/Relationship		. Mailing Address (Stree	t and Number or Rur	al Route Number,	City or Town, State, Z.	ip Code)
Σ	elth a		Angie M. McNeal	/Daughter	2127 Harl	oor Drive,	Annapol:	is, MD 21	401
ē,	item othe		20a. Method of Disposition	camata	f Disposition (Name of ry, crematory or other pla	ace)	Date 2	0c. Location - City or 1	Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1∑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		ection Ceme		/2006	Clinton	, MD
=	ertm orta		21. Signatule of Funeral Service Lic		22. Name and Addr	-		uneral Hom	e
B	Depermination of the service of the		I Shart	They to ITT	4001	Benning R	d., N.E.	Wash., DC	20019
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death. Do by one cause on each line. a. EVP STD GS Due to (or as a consequence	REMAL T	ing, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
,8760,	cate be executed physicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequence					
× 6	ding se at	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				22d Date of deli	.051
P.O. Box	The law requires that the death certific sie has been signed by the ettending f age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnant 5 □ Other (specify)	cy		23d. Date of deliment	Day Year
<u>σ</u> .	tw requires that s been signed b should be deta	by PI	Part II. Other significant conditions	contributing to death but not resulting in	n the underlying cause g	iven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds	uire n sig	D D					1 ☐ Yes	s 2 2 No 3 □ Pro	bably 4 Unknown
Records,	w rec	Completed					24a. Was an	24b. Were aut	opsy findings available
Re	he lav s has ge 2 :	Ĕ					autopsy	prior to c ed? death2	ompletion of cause of
a			25 Man ages referred to medical						2 No
Ξ	ysician: The is certificate had director, page	Be	25. Was case referred to medical examiner?	Hospital:	_ 0	har	h (Check only one		
of Vital	Physician: this certific ral director,	2	1 TyYes 2 No 27. Man y r of Death	1 Inpatient 27 EH/OL	JIDALIEFIL 3 DOA	4 Nursing He		nce 6 Other (Spec	ify)
Ž.	ding I	ō	1 Matural 5 ☐ Pending	(Month, Day Year)	Time of 28c. Injury W		28d. Describe how	w injury occurred	
Sic	Attending r death. ector: After by the fune	cat	2 Accident investigat 3 Suicide 6 Could not	he]Yes 2 □No			
Division	or At after of Direction by	Certification:	4 Homicide determine		arm, street, factory, office	'	City or Town,	eet and Number or Ru. State)	ral Route Number,
	rai C		<u> </u>						
	To the Mospitel or Attending Ph within 24 hours elter death. To the Funerel Director: After th comp stely filled in by the funeral	Medical	29a. Certifier 1 ☐ Certifying (Check only 2 Medical Ex	Physician: To the best of my knowledge aminer: On the basis of examination an and manner stated.	e, death occurred at the ind/or investigation, in my	ime, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29c. Licer	se number	29	d. Date signed (Month	, Day, Year)
l ,			Moulaite	The Shell air	0.	.C.M.E.		March 18,20	006
N	(3)		W 44 A	o completed cause of death (Item 23a)	(Type, Print)				
1			MARGARITA	1 KOREL	111 Penn St	reet Ralt	imore M	zvizna 21	201
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature			-	111	
1	Registi	ar	MAR 2 3 2	086 Steel #	And				
DH	MH 17 Rev 1/2	001			1				

ORIGINAL

		1 - For Registrar	State of Maryla	•	artment o				giene Reg. No.)6	10853
Physi /Med		1. Decedent's Name (First, Middle, Last, William G. W						2. Date of Dea Month March	Day	2006	3. Time of Death 12:24A M
Exam		4a. Facility Name (If not institution, give 5703 Cypress	Creek Drive	#002		wn, or Location Hyatt	svill		P		George's
Funera Directo		5. Social Security Number 6. Sec. 578-70-9290	7. Age (In yn	s. last birthday) 4 Yrs.	Months D	ear If Unde ays Hours	Min.	8. Date of Birt (Month, Day Oct. 2	, 1951	9. Birthp Cour Was	place (State or Foreign h., DC
e Maryland 3a-f ehow	ctor	10a. State 10b. County Maryland Prince G		City, Town or Lo		tsville				1	1 MYes 2 No
with th	i Dire	10e. Street and Number 5703 Cypress C	reek Drive		10f. Zip Co		782		10g. Citizen of		ntry? States
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiane. Important: if Item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Exempler must be halfilled at	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Decedent If Yes, specify	of Hispanic O Cuban, Mexica	rigin? (Spe an, Puerto l	ecify Yes or No- Rican, etc.)	- 14. Ra	ack, White,	
Maryland 21215-0036 nd 2 should be filed within 72 hours af lith and Mental Hygiane. 27 ie marked other then "naturel", or r traumatic event, the Madical Exemp	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual O kind of work d DO NOT use r	lone during mo etired)			16b. Kind of		•
filed v Hygia other t	Be Co	17. Father's Name (First, Middle, Last)	2		Medica	al Tech		an (First, Middle,		Govern	ment
ylan buid be Mental erked	To B	William War							Annie T	ucker	
Mar Id 2 shu Ith and Ith and Ith and Ith and Ith and Ith and Ith and Ith and Ith and Ith and Ith and Ith	19a. Informant's Name/Relationship (Ty Annie Ward/Moth						W. Was			•	
of Heal		20a. Method of Disposition 1		Place of Dispo cemetery, cre	osition (Name of matory or other	of r place)		ate	20c. Location	- City or To	own, State
Baltimore, Dermit. Pages 1 a Department of Her mportant: if item any injury or othe		4 □ Donation 5 □ Other (Specify) 21. Signature of Pineral Service Licens			od Ceme	-	3/21/	/2006 Stewart	Washi		
Depa Impo		21. Signature of Funeral Service Licens	Levail TI	Τ, Ι΄				d., N.E			
Physiciar /Medica Examine		23a. Part1. Enter the disease, or complete shock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate	a. Athrosc Due to (or as a consolous a consolous consolous a consolous consolous consolous a consolous consolous a consolous consolous a consolous consolous a consolous consolous a consolous a consolous consolous a consolous consolous a consolous consolous a consolous consolous a consolous cons	<u>lerotic</u> equence of):					rest,		Approximate Interval Between Onset and Death
. BOX 68/6U, death certificate be executed e attending physician and id or use as the burial-transit	edicai Examiner	cause, Enter Undertying Cause (Disease or injury that inflated events resulting in death) Last	Due to (or as a conse								
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3[□Ectopic pregr □ Other (specif					ate of deliver	ery Day Year
ecords, P.O. law requires that the as been signed by th	ğ	Part II. Other significant conditions con	ntributing to death but not re	esulting in the u	underlying caus	e given in Part	1.		obacco use co res 2 🗆 No	**	he cause of death? pably 4 Unknown
Tha Tha	Completed							24a. Was autop perfo 1 Yes		prior to co death?	psy findings available impletion of cause of
Of VITAL Physicien: The Physicien: The Physicien: The Physicien The Physicien Physicia	To Be	25. Was case referred to medical examiner? 1X Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other		n <i>Check only o</i> ne 5 X Resid		ther (Snecit	(v)
//SION Of VITAI Attending Physicien: r daath. betor: After this certifica by the funeral director, to		27. Manner of Death 1 □Xtatural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?	1	28d. Describe h			Y /
in Pictor	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	reet, factory, of	fice	4	28f. Location (S City or Tox		nber or Rura	al Route Number,
Mospital 24 hours a Funaral I	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	th occurred at the	he time, date a my opinion, de	and place, a	and due to the e	cause(s) and n date and place	nanner as s e, and due to	tated. the cause(s)
To the within 2 To the complet	Med	29b. Signature and title of pertitier	11/1/2011	/	29c. Li	cense number			29d. Date sign	ned (Month,	Day, Year)
2		fact N. U	VXIII			1313	0		Mar	ch 20	, 2006
K 76)		30. Name and address of person who ca				Ave.,	N.E.	Wash.,	DC 200	02	
Regis	tate trar	31. Date filed (Month, Day, Year) MAR 2 3 2006	32. Registrar's Sig	nature	w						

Norman Junior Walker 2nd

State of Maryland / Department of Health and Mental Hygiene

glerie	n	1	\cap	Q	5
Reg. No.	10	U	U	U	U

		•	1 - State Registrar		C	Certifica	te of	Death			Reg. Nö	UUb	1000) H
	D		1. Decedent's Name (First, Midd	lle, Last)						2. Date of De Month	ath Da	y Year	3. Time of 0	Death
	Physici /Medic		NORMAN	JUNIOR WALKER I	Ι					March		2006	11:00	O P ^M
	Examin		4a. Facility Name (If not institution	on, give street and number)		4b. City	, Town, o	r Location of				County of Death	1	
			Prince George					ever1			P	rince G		
	Funeral		5. Social Security Number	. ER 11 0 T E	rs. last birthi Yr	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da MARCH	th y Year)	9. Birth	pplace (State or unitry) VIRGIN	Foreign
	Director		235-27-2705 Usual Residence of Decedent	1×1×2 21		5.		<u> </u>		MARCH I	.3 L	985 WEŠŤ	VIRGIN	ILA
	and		10a. State 10b. County	y 10c.	City, Town	or Location							10d. Inside City	y Limits
	Mary	ō	MD PRINC	EE GEORGE'S S	гат рт	EASANT	,						1 X Yes	2 No
	28a	Director	10e. Street and Number	н онокон в			p Code				10g. Cit	izen of What Co	untry?	
	filed within 72 hours efter deeth with the Maryland Hygiene uthar than "naturel", or Itema 23a or 28a-f ahow uthar than "naturel", or Itema 23a or 28a-f ahow ant, I're Medical Examiner must be notified at	ā	6108 SEAT PLE	ASANT DRIVE		20	743					U.S.A.		
	deeth	Funeral	11. Marital Status	12. Was Decedent Ever in	ı U.S.	13. Was Dece	edent of H	lispanic Ori	gin? (Spe	cify Yes or No)-	14. Race - Amer		
9	or its	Ē	1 Never Married 2 ☐ Mar			1 ☐ Yes		an, Mexicar		Hican, etc.)		Black, White		
21215-0036	ral',	d by	3 Widowed 4 Divorce	d If Yes, Give Year or Dates:		1 🗆 105	243 190	Specity:				Specify: BLA	ACK	
ည	72 h	Completed		nt's Education est grade completed)	(0	ecedent's Usi Give kind of w	ork done	during mos	t of workir	ng	16b. K	ind of Business/I	ndustry	
2	han han	ig.	Elementary/Secondary (0-12)	College (1-4or 5+)		ife. DO NOT : DENT	use retired	d)			PRT	VATE		
N	filed v Hygie other t	ပိ	12th 17. Father's Name (First, Middle,	(act)	310	DENI		10 Math	rie Name	(First, Middle				
Maryland	\$ <u>a</u> a	Be	NORMAN JR. WAI							GREGOR		Sumamer		
Ž	should nd Men marke umatic	ဥ	19a. Informant's Name/Relation		19h A	Aziling Addres	s (Street	and Numbe	ar or Bura	I Route Numb	er City	or Town, State, Z	in Code)	
<u>8</u>	2 8 9 5		CANDISE SPRI								-	SA N T, MAR		0743
ē,	Heelth tam 27 tam 27 other tr		20a. Method of Disposition		b. Place of D	isposition (Na	ame of		- topological and the state of	ate		ocation - City or		0743
<u>o</u>	ages ant of it: If i		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (crematory or		1	2/2/	/2006	D T 171	DDATE M	ADSZT AND	
altimore,	orten orten injur		21. Signature of Funeral Service		RIVEKI 7	ALE CR						ERDALE,M FUNERA		
B	permit. Pages 1 Department of H importent: If its any injury or ot once.		* K D A	1anda VV								ARYLAND	20785	
			23a. Part1. Enter the disease, of	complications that caused the donly one cause on each line.	eath. Do no								Approximate)
	Physician		Immediate Cause (Final	•		sund		(CE)	-5	. (Interval Betw Onset and D	
and the second	/Medical		disease or condition resulting in death)	a. Due to (or as a cons			0	_4/	01	405	20			
	Examiner		Convention link and distance	b										
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	зе циелсе об).								
	acute ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c										
ŏ,	e exection a		resulting in death) Last	Due to (or as a cons	sequence of):						}		
68760	eath certificate be executed ettending physicien and for use as the burial-transit	Medical		d			-							
×	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pre	an anav								- 100	
80	death e etten	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F	etal death	3 ☐Ectopic 5 ☐ Other (s		1				23d. Date of deli Month		'ear
o.	the d y the	ysic	1 ∐ Yes 2 □ No 9 □ Unknown	9□ Unknown	or again	o 🗆 Other (s	pochy) _							
٥.	The law requires thet the death ite hes been signed by the etter bage 2 should be detached for u	by Physician	Part II. Other significant condit	tions contributing to death but not	resulting in t	he underlying	cause giv	en in Part I		23e. Did 1	obacco	use contribute to	the cause of de	eath?
g	puires n sign									10	Yes 2	⊒ Ń o 3⊟Pro	obably 4 🔲 U	nknown
Ö	w require s been si should t	Completed								24a. Was	an	24b. Were au	topsy findings a	available
æ	The lav	mo								auto	rmed?	prior to death?	completion of ca	iuse of
ta		BeC	25. Was case referred to medical	al				26 Place	of Death	(Check only	2 No	/ZNY es	2 No	
\geq	ysician: is certific director,	To B	examiner? 1 □x/es 2 □ No	Hospital: 1 ☐ Inpatient 2	2 🔀 ER/Outp	atient 3 0	Oth	or				6 ☐Other (Spec	cify)	
Ö	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pend	28a. Date of Injury (Month, Day Year	28b. Tir	ne of ury	28c. Injur	y at	2	28d. Describe	how inju	ry occurred		
Division of Vital Records, P.O. B	Attending Physician: r death. ector: After this certific by the funeral director.	Certification:	2 Accident invest	tigation 3-18-06	100	. 95™		Yes 2 🗷	No.	Subje	ect	Shot	•	
<u>\S</u>	r Atto	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	not be mined 28e. Place of Injury - A building, etc. (Sp	t home, farn	n, street, facio	ry, office		2	28f. Location (Street al	nd Number or Ru	ral Route Numb	D0r,
	ital o irs eff rel Di		/ -		St	reet				2818 W	whi	2 Cuther coscut	MB	VE
	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	edicai	(Check only 2 Medica	ing Physicien: To the best of my all Examiner: On the basis of exam	knowledge, nination and/	death occurre or investigation	d at the ti	me, date ar	nd place, a ath occurre	and due to the ed at the time.	cause(s date an) and manner as d place, and due	stated. to the cause(s)	,
	thin 2 thin 2 the mple	Med	one) 29b. Signature and title of certifi	and manner stated.				e number				ite signed (Monti		
	N T S		250. Signature and title of certifi		200	2								
0	72		Talu (uonica-1	Ollo	احما	OCI	Æ			Mar	ch 19,20)06	
K	- (3)		Su. Name and address of person	n who completed cause of death (1 11		1 Da-	nn C+-	coct	Ro1+4	orc	Marylar	A 21201	i
	Sta	ite	31. Date filed (Month, Day, Year		ignature	A	r rei	пі опі	eet_	ратели	ore,	пагутаг	10 21201	L
	Registi		MAR 23	2006 Blane	K A	will								
DH	MH 17 Rev 1/2	001			-7		\							

			1 State	State of Maryland		artment of Hetificate of L			- "}	nnc	LOOFE
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	lilicate of L	Jean	2. Date of Dea	Reg. No.	000	3. Time of Death
	Physici		George Wilbur	Willison dr				March	Day 21	2006	10:10 P ^M
į.	/Medio Examir		4a. Facility Name (If not institution, give st		•	4b. City, Town, or	Location of De			County of Death	
			8318 Langmaid Rd.			Newark				Worcest	er
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia M 2□ F	**	If Under 1 Year Months Days	If Under 24 H	Irs. 8. Date of Birt in. (Month, Day	h v. Year)		place (State or Foreign ntry)
Н	Director		Usual Residence of Decedent	76	Yrs.			Sept. 2	2, 1	929 M	D´´
	land ow		10a. State 10b. County	10c. City,	Town or Lo	cation				1	10d. Inside City Limits
	Many	ţ	MD Worceste	r Newa	rk						1 Yes 2000
	h the	lrec	10e. Street and Number	i incha	i K	10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	23a c	alD	8318 Langmaid Rd.			21841			USA		
	r dea	Iner	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? n. Mexican, Pu	(Specify Yes or No-		14. Race - Ameri Black, White,	
36	s afte	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give		∏Yes 200 No	Specify:	, 2.2.,		Specify: Wh	
Ş	within 72 hours after death with the Maryland ene. than "natural", or lieme 23a or 28a-f ehow the Madical Exertinal must be notillied at	edt	15. Decedent's Educ	Year or Dates: Korea	16a Decer	lent's Usual Occupa	tion		16h Kir	nd of Business/Ir	
5	on n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done di DO NOT use retired)	uring most of a	working	TOD. KI	10 01 00311632/1	laustry
2	giene giene gr tha	ĕ	12	College (1-401 5+)	Cont	ractor			Dry	wall	
Maryland 21215-0036	al Hy al Oth	Be	17. Father's Name (First, Middle, Last)	·				lame (First, Middle,			
₹	Meni	<u>ا</u>	George Wilbur Will					Roberta W			
Mar	12 sh h and h and T te m		19a. Informant's Name/Relationship (Typ	e, Print)				Rural Route Numbe			
ė,	1 and Healt em 2		Barbara Willison 20a. Method of Disposition	20b. Pla		Langma1a sition (Name of	ка.,Р.	0. Box 55		wark, Mo	
nor	eges ant of tr: If it		1 ☐ Burial 2 ☒ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State - COI	metery, cren	open Crem	· 1	25-2006		,	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Examinat must be notified at ADEs.		21. Signature 1 Fune 1 Service Licenses				, •	he Burbag		-	
m	Der Per		1 At Mil Du	tale	1	08 Willia	ım St.,	Berlin,	Md.	21811	Jille
П			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death.							Approximate Interval Between
i I	Physician		Immediate Cause (Final disease or condition	Myocarchal.							Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	/				/	- IIIWICS
	Lamine	_	Sequentially list conditions, b.	Hotenicschni		ascular Disc	ise				years.
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
<u>,</u>	execu n and al-tra	xar	that initiated events c. resulting in death) Last	Due to (or as a conseque	ence of):						
38760,	ficate be executed physicien and is the burial-transit	dicail	L d.								
	rtificat ng phy es th		IS SENALS								
Box	th certendir	an/h	230. Was decedent pregnant	c. If yes, outcome of pregnand		Ectopic pregnancy			2	3d. Date of deliv	,
о. П	Attending Physician: The law requires thet the death certif radeath, radeath, ard death. sclor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use expenses the funeral director.	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of dea 9☐ Unknown		Other (specify)				Month	Day Year
<u>~</u>	het th ad by detacl	유	Part ff. Other significant conditions cont	ributing te-leath but not result	ting in the ur	dorhing course gue	n in Dort I	220 Did to	bassa	no apatributo to t	he cause of death?
Division of Vital Records,	signe d be		Chronic Chistourt	ve Palmenery D	18-11:12 1	idenying cause give	iliraiti.				pably 4 Unknown
cor	w requ	lete	Mutido Carl Daix	Octor Prints to	73000						
Re	he lay e has	Completed	So P 11	1 -> "				24a. Was a autop	sy	prior to co death?	ppsy findings available mpletion of cause of
ta	an: T tificat tor, pa	0	25. Was case referred to medical	cur Diseuse			26 Place of F	1 ☐ Yes Death Check only or	2/1No	1 🗆 Yes	2 No
₹	ysici iis cer direc	lo B	examiner?	spital:	R/Outpatien	Otho		Home 5 Resid		☐Other (Specia	(v)
0	ng Ph Iter th neral	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe h			17
Sio	leath. lor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be				es 2 No				
$\frac{1}{2}$	or Att	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow	itreet and m, State)	Number or Run	al Route Number,
_	spital ours sours meral filled		29a. Certifier Certifying Physi	cian: To the best of my know	ledge doath	cooursed at the time	data and pla				
	To the Hospital or Attending Physician: The law requires thet the death certific within 24 hours after death. To the Fundral Director: After this certificate has been signed by the attending a completely filled in by the funeral director, page 2 should be detached for use established.	Medicai	(Check only 2 Medical Examine one)	er: On the basis of examination and manner stated.	on and/or inv	estigation, in my op	inion, death oc	ccurred at the time, of	date and	and manner as s place, and due to	tated. the cause(s)
	To the withing To the Comp	Me	29b. Signature and title of certifier			29c. License	number	12	29d. Date	signed (Month,	Day, Year)
			Livenin	\supset		730	619		3/2	23/06	
	د .سر		30. Name and address of person who com				1 -			1	
D	N 541		31. Date filed (Month, Day, Year)			en Cory BIVO	Site	1 Repli	N	nary land	21871
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire	2					

		1	For State	State of Maryland		artment of F rtificate of			giene Reg. No.	5	10856	
	2.55		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of De	ath	Yeer	3. Time of Death	
	Physicia		Clarence Henson Willis					March 29, 2006			6:37 P M	
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of I									
	Examin	ei	St. Mary's Hospit			Leor	nardtown		St. 1			
). -}	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	h y, Year)	9. Birthp Cour	lace (State or Foreign try)	
	Director		236-26-0701	¥M 2□F 84	Yrs.	1000000		Dec 5, .	1921		ginia	
-ta	p.	- H	Usual Residence of Decedent 10a, State 10b, County	10c City	, Town or Lo	ncation				1	Od. Inside City Limits	
	arylar show										1 ☐ Yes 2 ☐ No	
	8a-f	cto	Maryland St. Mary	7'S	Park	Hall 10f. Zip Code			10g. Citizen of W	/hat Cour	atry?	
	or 2	Director	10e. Street and Number								,	
	s 23e	in in	46788 Glenn Mary	Farm Road 12. Was Decedent Ever in U.S	S 13		1667 Hispanic Origin? (Sc	ecify Yes or No	US/ - 14. Race	- Americ	an Indian,	
	within 72 hours after death with the Maryland ene. than "natural", or tlems 23e or 28e-f show the Medical Evanings must be collibed at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Amed Forces?			Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		k, White,		
30	rs aft	byF	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify	Whi	te	
3	tura tura		15. Decedent's Edu	cation	16a. Dece	dent's Usual Occu	nation	king	16b. Kind of Bu	siness/In	dustry	
Ç	n na	Completed	(Specify only highest grad	e completed) College (1-4or 5+)	life.	DO NOT use retire	during most of work d)	ong				
7 7	r tha	mo	12	Gollogo (* 16. 51)	C.	arpenter			Self Er		red	
<u> </u>	be filed within 72 hours after death with the Marylan tal Hygiene. Id either than "natural; or Items 23a or 28a-f show other than "natural; or Items 73a or 28a-f show event, Ite Medical Ergenings mast be recilified at	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle	, Maiden Sumam	e)		
<u>a</u>	should be f marked of matic eve	TO E	Clarence Henry Wil	llis			Dora Whi					
Maryland 21215-0036	ds or m		19a. Informant's Name/Relationship (T)	rpe, Print)			and Number or Ru			State, Zip	Code)	
	s 1 and 2 of Health a itam 27 ls		Patty Schmidt		-		Park Hal			O'1 T	- C	
e,	of He of He litam		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ F	_ ,, _, 0	emetery, cre	osition (Name of matory or other pla		Date	20c. Location -	City or 10	own, State	
Ĕ	permit. Pages Department of I Important: If its any injury or of once.		'4 □Donation 5 □ Other (Specify)		Marylan Veteran	s Cemetery	Apr 8	3. 2006	Chelten	ham,	MD	
	mit. poartr poorts y inje		21. Signature of Funeral Service Licens	99	2	Name and Addr Mattingle	ess of Facility ey-Gardiner	Funeral 1	Home. P.A.			
	Physician /Medical Examiner		P.O. Box 270, Leonardtown, MD 20650									
			23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Caudities p: rate of faulure Onset and Deal									
			resulting in death)	Due to (or as a consequence								
			Sequentially list conditions.	b. End S	stage reval dis.							
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	or as a consequence oi).							
	and and trans	am	that initiated events resulting in death) Last	quence of):								
, 0,	oe ex			CH =								
8760,	cate be executed physician and the burial-transit	dical		d								
9	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	0	IF FEMALE:	23c. If yes, outcome of pregna	ancv				23d. Da	te of deliv	ery	
Box	attendation (lan	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	☐Ectopic pregnan☐ Other (specify)	cy		Mo	onth	Day Year	
o.	the a	ysic	1 ☐ Yes 2 Ō(No 9 ☐ Unknown	9□ Unknown								
<u>α</u>	that the	by Physician/M	Part II. Other significant conditions co	ontributing to death but not res	ulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use conf	ribute to	the cause of death?	
ds,	signed d be del							1 🗆	Yes 2□No	3 ☐ Pro	bably 4 Unknown	
Records,	require been si should t	Completed						24a. Wa			opsy findings available	
36	has has	mp						per	ormed?	death?	ompletion of cause of 212 No	
			as We want to medical				26. Place of Dea	1 ☐ Yes	-7	1 🗌 Yes	280 140	
Ζij		Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpation	ent 3 DOA	thor			ce 6 ☐Other (Specify)		
of	Phys raidi	To	1 Yes 2 XNo 27. Magner of Death	28a. Date of Injury	28b. Time	of 28c. lnj		-	how injury occur		-,,	
Division of Vital	ding h. Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of							
Si	Attending r death. sctor: After oy the fune	fica	3 Suicide 6 Could not be	200. Flace of injuly - All	ome, farm, s	street, factory, office	9		(Street and Numi	oer or Ru	ral Route Number,	
Ω	or Attendation of Attendation of Director:	Certification;	4 Homicide	building, etc. (Special	<i>TY)</i>			Only on t	om, olalo,			
	Hospital		29a. Certifier 1 Certifying Ph	ysicien: To the best of my kno niner: On the basis of examina	owledge, de	ath occurred at the	time, date and place	e, and due to th	e cause(s) and m	anner as	stated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Exert one)	and manner stated.	ation and/or			onou at the tille				
	To the within To the Comp	Σ	29b. Signature and title of certifier				nse number	66	29d. Date signs			
			-DSh	an _		100	11706	183	3.50	,	~	
			30. Name and address of person who									
			A.D. Shah, M.D.	St. Mary Mo		t Bldg L	eonardtow	n, MD 2	0650			
, A		ate	31. Date filed (Month, Day, Year) MAR 3 0 200	32. Registrar's Sign	ature							
	Regis	Mel.	min in U U CUC	1 1 1 2 2 2 2 2 2 2 2 2		DAME /						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene ()

10857

				0.0.0	ar y rarr	C	ertifica	te of	Death			Reg. No.		10	007
		-	1. Decedent's Name (First, Middle, La	st)	-			-		- 1:	2. Dete of Dec	eth	JT CV	3. Tim	ne of Death
	Physici		Gordon Alden Wern	ner							Month March	27, 200	Year OG	6:0	5 p.m.
	/Medio Examir		Fecility Neme (If not institution, give street and number) 4b. City, Town, or							wn, or Loc	ation of Death	4c. County	of Death		
4			Goodwill Mennonit								le	Garre	tt:		
	Funeral Director		196-18-0530	ex 7. Ag 【XM 2□ F		lest birthda Bl Yrs.	y) If Under	or 1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Date) Dec 22	v. Year)	Coui	ntry)	ate or Foreign vania
	pue ≱.		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or	Location						-	10d. Insid	de City Limits
	Manyle f sho	ō	MD Carrett		Cwa	ntsvi.	110							10	Yes 2XXX0
	the 3	5	MD Garrett 10e. Street end Number		GLai	ICSVI.		ip Code				10g. Citizen of	What Cou	ntry?	
	3a or	Funeral Director	891 Dorsey Hotel H	Rd., Apt.	23		21:	536				USA			
	deeth	ner	11. Marital Status	12. Was Decedent Armed Forces?		,S. 13	. Was Dec	edent of h	lispanic Orig an, Mexican,	gin? (Spec	cify Yes or No-		ce - Ameri		n,
Maryland 21215-0020	is 1 end 2 should be filed within 72 hours efter deeth with the Marylend of Health end Mentel Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at		1 ☐ Never Merried 2 【文 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 1 If Yes, Give Year or Dates:	vo WW				Specify:	, Fuerto A	nosti, etc.)		^b :Whit		
5-0	72 ho) te	15. Decedent's Ed (Specify only highest gre	fucation		16a. Dec	edent's Us	ual Occup	ation during most	of workin	a	16b. Kind of B	usiness/In	dustry	
7	ithin and and and and and and and and and an	Completed by	Elementery/Secondary (0-12)	College (1-4or	5+)				during most d)			Retai	רי		
12	led w		12 Call and blame (Circl Middle Look			Sale	s vebi	. esei	tativ		/Eiret Middle	Maiden Sumar			
anc	be fill H of off	Be	17. Fether's Neme (First, Middle, Last,	'								Maiden Sumai	110)		
2	12 should be filed withir n end Mentel Hygiene. 'is marked other than raumatic event, the M	ဥ	Ralph H. Werner 19a. Informant's Name/Relationship (Tyme Print)		19h Ma	ilina Addre	ss (Street		da Bo		er, City or Town	State Zii	Code)	
<u>≅</u>	d2s then then trau		Alma E. Werner/W												D 21536
<u>6</u>	Health Health tem 27 i		20a. Method of Disposition		20b. F	Place of Dis					Date	20c. Location			
Baltimore,	permit. Pages 1 and 2 should be filed withir Department of Health end Mental Hygiene. Important: If Item 27 is merked other than any injury or other traumatic event, the Motice.		1 🔀 Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif							d. Ma	arch 30	,2006 I	aVal	e, Mi	D
Ħ	ortar injur		21. Signeture of Funeral Service Licer									neral H			
Ä	Den in personal perso		De Lyerd	Ruma	<u></u>						sville,		1536		
			23a. Pert1. Enter the diseese, or com shock, or heart failure. List only	plications that caused one cause on eech li	d the deat ne.	h. Do not e	nter the mo	ode ot dyi	ng, such es (cardiac or	respiratory ar	rest,	1	Approxi Interval Onset a	imate Between and Death
	Physician /Medical		Immediate Ceuse (Final	Con	ann	Lin	04	pa	2+	En	10110	0)	!		
	Examiner		disease or condition resulting in death)	e. 0 / 0	Due to (c	or as a cons	equence of	<u>en</u> :		X	elur easc		1		
	p #	ner	_	· Coro	MA	101	an.	for	in &	25	casa	2			
	ecute and -trens	Examiner	Sequentially list conditions, Due to (or es consequence of):												
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of): Due to (or as e consequence of): Due to (or as e consequence of): Due to (or as e consequence of):															
68760,	phys phys	edicai	that initiated events resulting in death) Last		Due to (o	r as e cons	equence of):					1		
	certif ding se as	2		d											
Box	leath cer ettendir d for use	ciar	Pert II. Other significant conditions of	cetributing to dooth b	ut not rec	ulting in the	underlying	Cause oi	ren in Pert I		23h Did i	obacco use co	ontribute (o the car	use of death?
P.O.	the contraction of the achee	Physician/	Per II. Other significant conditions of	onthibuting to deetil b	u(110(163	asting in the	didonying	oudso gi	on any oren.		10		2 Probably 4 □ Unki		
	s that med l	by P											,		
of Vital Records,	v requiras that the death ce been signed by the ettendi should be datached for use	8									24a. Wes perfo	en autopsy rmed?	av	ailable p	psy findings rior to
ပိုင်	e law re has be ge 2 sh	Completed								_			of	death?	of cause
<u>=</u>	The ate h page	S S									101	res 2.₽No	1	☐ Yes	2 No
/ita	Physician: The rthis certificate rel director, pag	Be	25. Wes case referred to medical examiner?	Haanitali				Ott	- /		(Check only o				
5	Physic this c	ဥ	1 Yes 2 No	Hospitel: 1 Inpatio		ER/Outpat 28b. Time		JUA	4♥ Nu			dence 6 □Otl		fy)	
	Ing F	lo	27. Menner of Death 1 ☑ Naturel 5 ☐ Pending 2 ☐ Assident investigatio	28e. Date of Inju (Month, De	y Year)	Injury		28c. Inju Wo	rk? IYes 2⊟1		od. Describe i	iow injury occu	100		
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident Investigatio 3 Suicide 6 Could not b		ury - At he	ome, tarm,					8f. Location (S	Street and Num	ber or Rur	al Route	Number,
S	aftar Oire d in b	eri	4 Homicide	28e. Place of In building, et	c. (Specif	y)		•			City or Tov	vn, State)			
	To the Hospital or Attending Physician: The I within 24 hours aftar death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best niner: On the basis o and manner st	f examina	wledge, de tion end/or	eth occurre investigation	d at the ti	me, date and opinion, deet	d place, ar	nd due to the d et the time,	cause(s) end m date and place,	anner es s	stated. to the cau	ıse(s)
	of the of the omple	N N	29b. Signature end title of certifier				2	9c. Licens	se number			29d. Date signe	ed (Month,	Dey, Ye	er)
	F S F Ö		Del B	mo V	m	1		Do	034	23	/	3/27	11	,	
	15 . 1 / A		30. Neme end eddress of person who	completed cause of c	leath (Iten	n 23e) (Typ	e, Print)					0/0/	,		
	10414		Robin Bissell	MD L	24	mil	er s	+	60	ants	ville	ma	21.	536	5
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registr	er's Signa	ature	1	/				1			
	Registr	ar	MAR 2 8	2006	Carrier of	10	Brook	8 8							

				State of Maryla	-	rtificate of			Reg. No.	16	0858	
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of De Month	Day	Year	3. Time of Death			
	/Medi		Alta Ruth Yoder				# 05 T	_	26, 2006		4:15 AM	
1	Examir	ner										
			5. Social Security Number 6. Sex		s. last birthday,	If Under 1 Year	Grantsvi	Done of Die	Garre		ce (State or Foreign	
	Funeral Director			M 2M F 89	Yrs.	Months Days		May 2,	y, Year) 1916	Country	ce (State or Foreign y) ylvania	
	ס		Usual Residence of Decedent					indy 27	1510	I CITIE	yxvaniza	
	nrylan show	_	10a. State 10b. County	10c. C	City, Town or L	ocation				10d	I. Inside City Limits	
	Be-f s	cto	PA Somerset	t Sp	rings						1 ☐ Yes 2 📉 No	
	vith th	ä	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country	ρ	
	s 23s	a.	1654 Springs Rd.	In this part of Free is	11.0	15562	11	7	USA			
_	hours after death with the Maryland urel', or liems 23a or 28e-f show al Examiner must be multiled at	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	0,5. 13.	If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert	pecity Yes or No o Rican, etc.)	Blac	e - American ck, White, etc		
2	urs af	by F	3X Widowed 4 □ Divorced	1 ☐ Yes 2√ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:		Specify	"White	<u> </u>	
2-0020	be filed within 72 hours after death with the Manylan Ital Hygiene. d other then "naturel", or liems 23a or 28e-f show event, i'ra Medical Examiner man be notified at	te E	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Bu	usiness/Indu	stry	
7	thin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wor ed)	King				
7	filed within 72 Hygiene. ther then "nat	Completed	0		Homen	aker			Own Ho			
and	ld be fil ental H ked oth Ic even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surnan	10)		
5	a in M	2	Ellis D. Shoemaker	0.1.1	401 14 77	4.11 (0)	Nettie N		O			
	tra tra		19a. Informant's Name/Relationship (Type Alice M. Miller/Sis				t and Number or Ru		•		•	
ā,	l an feal m 2	- 4	20a. Method of Disposition		Place of Disp	osition (Name of	ings Rd.,	Date	20c. Location -	1555 City or Towr		
baltimore,	ages ant of it: If if		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		matory or other pla Cemetery	1	mah 20				
	permit. Pages ' Department of H Important: If ite eny Injury or ot once.		21. Signature of Funeral Service License			2. Name and Addr		rch 29, Jewman Fi		Spring		
ă	permi Depar Impor eny Ir		De Low Day	man	F	O. Box	275, Gran			1536	1 •11 •	
		3 5	23a. Part1. Enter the disease, or complic	cations that caused the de							pproximate nterval Between	
3	Physician		23a. Part1. Enter that disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death									
	/Medical		Immediate Cause (Final disease or continuo resultino res									
	Examiner	L	resulting in death) a		(or as a conse	1						
-	ed sit	Examiner	a b	BILATE	RAL	PNG	=UMON1	A			WEEK	
	ficate be executed physician and is the burial-transit	xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							2		
09/90	siciar buria	ie	cause. Enter Underlying Cause (Disease or injury that initiated events)N		i	XWKS					
9	tificate g phy as the	edicai	resulting in death) Last	1	or as a consec	quence of):				1		
DOX	n cert anding use a	M	d.	HNEMI	Λ					11	youth.	
	v requires that the death certificate be executed been signed by the attending physician and should be detached for use as the bunal-transit	Physician/N	Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	ınderiying cause gi	iven in Part I.	23b. Díd 1	obacco use co	ntribute to th	he causa of death?	
5	at the	Phys	Alabaina 1	Marshir	, V.	abote	11/11/1				bly 4 □ Unknown	
'n	es the	þ	1112 Meriale (Jarran 1	, 01	C Seg Ju) Mell	M)		1		
ecords,	s uee een s	Completed	Broact CANO	ER				24a. Was perfo	an autopsy rmed?	availa	autopsy findings able prior to	
ည်			510031 0/1100							of de	pletion of cause ath?	
<u>.</u>	: The cate I							1 🗆 1	res 2 No	1□\	res 2 No	
N Ea	ician certifi rector	Be	25. Was case referred to medical examiner?	ospital:		Ot	hor	th (Check only o			A	
5	Phys r this gral di	. To	1 ☐ Yes 2 ☒ No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	☐ ER/Outpatie	IL SCI DOA	4 Li Nursing n		lence 6 🔼 Oth		HSSISTES	
DIVISION OI	th. : Afte	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wo	ork?]Yes 2∐No		,,		LIVING	
<u>S</u>	Atter er dea ector by the	iffice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At	home, farm, st	reet, factory, office		28f. Location (Street and Number or Rural Route Number,				
5	tal or rs after all Dir	Certification:	4 - Tromicide	building, etc. (Spec	aly)			City or Tov	m, State/			
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examin	ician: To the best of my kn ar: On the basis of examin	owledge, deat ation and/or in	h occurred at the ti	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and ma	nner as state and due to th	ed. ne cause(s)	
	ithin 2 o the	Med	one) 29b. Signature and title of certifier	and manner stated.			se number		29d. Date signer			
	F≯Fŏ		Dalachet 1	1 muchi	MA		8655		2/2/	1 16		
1	1		30. Name and address of person who cor	mpleted cause of death /lts	1 /		0000		2/26	100	†	
	1		Sabahat Nawab, M.D.	,			ville, MD	21536	,	/		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign		, 524.165						
	Registr	ar	MAR 2.8.2	HHM Mo-	3							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day **Physician** BENDER 4, 2006 APRIL 4:31 P. M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb. 24, 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Year 918 Months 1 ☐ M 2 ☐ F Maryland Yrs. 88 217-01-6415 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahov Item 27 is marked other than "natural", or Itama 23a or 28a-f ahov other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Fallston Md. Harford 10e. Street and Number 10g. Citizen of What Country? 21047 U.S.A. 2028 Oakmont Road, Box 2054 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ne any injury or other traumatic avant, the Mades once. (Give kind of work done during most of working life. DO NOT use retired) (Specify onfy highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margaret Hagen Earl Lanham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2028 Oakmont Road, Box 2054, Fallston, Md. 21047 19a. Informant's Name/Relationship (Type, Print) Bob Bender/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 4/7/06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End ghe disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed burial-transi Examl that initiated events resulting in death) Last and Due to (or as a consequence of): the eftending physician Box 68760 Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the eld be detached for P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has autopsy performed? certificate 2 No 1 ☐ Yes To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Drund 5 % D35528 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13 615 W. MACPHAIL ROAD DR. DAVID DUNN BEL AIR, MD. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 7 2006 Registrar

		State of Maryland / Department o	Health and Menta		6 10860						
		Certificate of Death Reg. No.									
	Physician	1. Decedent's Name <i>(First, Middle, Last)</i> Mary Byrd	M	ite of Death onth Day rch 30, 2006	Year 9:15 PM						
	/Medica * Examine	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location								
	LXamme	Bradford Oaks Nursing Home	Cheltenham	Prince	Georges						
	Funeral Director	5. Social Security Number 490-26-7367 6. Sex 1	s Hours Min. (M	B. Date of Birth (Month, Day, Year) Oct. 26, 1926 9. Birthplace (State or Foreign Country) MO							
	D.	Usual Residence of Decedent			40d Inside Other Limite						
	anyler show	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 12 Yes 2 □ No						
	8a-f	MD Prince Georges Cheltenham		40- 03							
	vith th	10e. Street and Number		10g. Citizen of W	mat Country?						
	ifter death with the Mar r frams 23e or 28e-f si iner most be notified	1025 Leferre Drive 206		USA es or No- 14. Bace	- American Indian,						
	item item	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Never Married 2 □ Married 11. Was Decedent Ever in U,S. If Yes, specify (1) If Yes, specify (1)	of Hispanic Origin? (Specify Y uban, Mexican, Puerto Rican,	etc.) Black	k, White, etc.						
N N	urs af		lo <i>Specify:</i>	Specify:	Black						
0200-61212	be filed within 72 hours after death with the Maryland tel Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Exarcher must be notified at	15. Decedent's Education 16a. Decedent's Usual Oc	cupation	16b. Kind of Bu	siness/Industry						
2	hin 7	(Specify only highest grade completed) (Give kind of work dc life. DO NOT use re	ne during most of working ired)								
7	led within 72 hoi ygiene. Ner than "natura it, the Medical It.	12 2 Homemaker		Own H							
Maryland	should be filed and Mentel Hygin marked other matic event,	17. Father's Name (First, Middle, Last)		, Middle, Maiden Surname	9)						
<u> </u>		Luther Cook	Amanda Tho								
<u>a</u>	2 9 is		eet and Number or Rural Rou								
	s 1 and r Health tem 27 other tr	8 1 8	Drive, Chelt		20623 City or Town, State						
0	0 0	20a. Method of Disposition 1☑ Burial 2 □ Cremation 3 □ Removal from State 1☑ Burial 2 □ Cremation Barracks Nation	olace)								
	men tant: jury	4 Dopation 5 Doner (Specify) Cemeterv	4/4/								
Baltimore,	permit. Pages Department of Important: if it any injury or once.	21. Sign-Ture of F neral Service Licensee 22. Name and Ac	dress of Facility Lonnin	ng Funeral S Oste Square	ervice						
_	20 = 6 a	L Sennis Pellmein	St Cha	arles, MO 6	3301						
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.	dying, such as cardiac or resp	iratory arrest,	Approximate Interval Between Onset and Death						
	Physician		\		Oriset and Death						
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. OVANA CAUC	1hUMA		months						
		Due to (or as a consequence of):									
H	e be executed sician end e burtel-transit	b									
<u>,</u>	te be executed ysician end le buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.									
/60,		that initiated events Due to (or as a consequence of):									
28	leeth certificate attending phy I for use es the	resulting in death) Last									
ROX	th ce tendii tendii or use	d									
	e dee	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I. 2	23b. Did tobacco use con	tribute to the cause of death?						
л О	ition: The law requires that the deeth certifica artificate has been signed by the attending phictor, page 2 should be detached for use as it			1 ☐ Yes 2 7 No	3 Probably 4 Unknown						
Ś,	signe			4a. Was an autopsy	24b. Were autopsy findings						
Ö	requi hould			performed?	available prior to complation of cause						
Hecords,	law hasb				of death?						
_	cate			1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No						
VItal	certif recto	25. Was case referred to medical examiner? Hospital: Hospital: A Discussion of DOA	26. Place of Death (Che		or (Consita)						
<u>o</u>	Physic rthis or all dire	1 Yes Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of Injury 28b. Time of 28c.		5 ☐ Residence 6 ☐Othe Describe how injury occurre							
0	ding th. Afte		Vork? ☐ Yes 2 ☐ No								
Division of	Attending Physicien: or death. sctor: Atter this certific by the funeral director,	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, off		ocation (Street and Numberity or Town, State)	er or Rural Route Number,						
É	s efte i Dire	4 Homicide determined building, etc. (Specify)		ny or Town, State)							
	To the Hospital or Attending Physicien: The law within 24 hours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in r	e time, date and place, and du	ue to the cause(s) end mai	nner as stated.						
	the H nin 24 nin 24 the F	one) and manner stated.									
	vithi To t	29b. Signature and title of certifier 29c. Lic	ense number	29d. Date signed	(Month, Day, Year)						
	1		17/3/	5/3/	106						
	5	30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print)	De 11th 115	FT Work	MG) MI ZITUL						
,	-	31. Date filed (Month, Day, Year) 32. Registrar's Signature	100	11,000	Ja-1 0 2017						
	State Registra	APR 0 7 2006 Brown & Sparle			•						
		The state of the s									

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** APRIL 3, KATHLEEN KENNEDY BAUMANN 2006 12:35 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BROOKE GROVE REHAB & NURSING CENTER SANDY SPRING MONTGOMERY 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Founds) AUG. 18, 1915 DETROIT, MI 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🗓 F 90 Director 176-12-4166 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "naturel", or iteme 23a or 28a-f ehov the Medical Examiner wust be notified at 1 XYes 2 No Directo MARYLAND MONTGOMERY SANDY SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18131 SLADE SCHOOL ROAD 20860 U.S.A. deeth by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If item 27 is marked oth eny lidury or other traumatic event ange. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL MALMBERG 2 MARGARET WALSH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115301 BAUGHMAN DR., SILVER SPRING, MD 20906 KERRY LeBOYER (DAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GATE OF HEAVEN CEMETERY 4/7/06 4 □ Donation 5 □ Other (Specify) ERIE, PA 21. Signature of Funeral Service Licenter BRUGGER FUNERAL HOME 1595 WEST 38TH ST., ERIE, PA 16508 men 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Gastronifertial Remorrage Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Þ cete has been sign, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending deeth. 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours e To the Funerel C completely filled in to cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 139793 ayeus De 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Da. duay, up 20832 Christopher J. Mays, mo 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 0 7 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TIFF BUNDVED51118 40 2000 1:50 9 1 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMORE BACTIMORE
If Under 1 Year If Under 24 Hrs. KEHAB. CENTER 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10M 20F Days Hours 92 217-18-1991 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show traumatic event, the Medical Examiner must be notified at BACTMORE 1 ☐ Yes 2 3 No Funeral Director FIEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 2105 ONE 11541 REEN IKE Race - American Indian, Black, White, etc. "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status should be filed within 72 hours after nd Mentel Hygiene. marked other then "natural", or Ite 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1942-Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 Widowed 4 Divorced WHITE 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, 90 NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AINTER OMMERCIAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumanne, Be (SARFIELD OTSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health er
Important: If Itsm 27 is
eny injury or other trau SUMMERFIELD $\mathcal{N}(0)$ Mυ JANE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date APRIL 8 PARKVILLE 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) EMETERY 2006 8899 HARFORD NO 21. Signature of Funeral Service Licenses 22. Name and Address of Facility ARKUILLE MD 21274 UNERAL 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MOSHEINER'S LYEARS alterno /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in tilated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use es the buriat-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant al time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? 1 ☐ Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 1 Yes 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred After t Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No within 24 hours efter death. To the Funeral Director; A 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) h olowo w 935BBB34 who completed cause of death (Item 23a) (Type, Print) 3000 COCH 80000 COCHED DARJAMA C GOS 20 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

APR 0 7 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. item#23a.27-28a-fuperMe.e85/s/4/19/06. TT-441-ally and March Illusian

	Unpend item#23: 1- For State Registrar	.\$7a?&&fMaH}1an&5/046 Ce	partment of Health and ertificate of Death	Mental Hygiene	
Physician	Decedent's Name (First, Middle, Las) 0 11		2. Date of Death Month Da	3. Time of Death
/Medical	JAMES WALLA	CEBEALL			31 2006 0928 ^M
Examiner	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Dea	th 4c	c. County of Death
	400 Millington Ave		Baltimore // If Under 1 Year If Under 24 Hrs		
Funeral Director		X M 2 G F 7. Age (In yrs. last birthda) Yrs.	Months Days Hours Min		1 A A A 1/
	Usual Residence of Decedent	0		3-26-3	31 MARYLAND
yland	10a. State 10b. County	10c. City, Town or I	· ·		10d. Inside City Limits
e Ma	MD	BALT	IMORE		1 ₹Yes 2 No
or 28	10e. Street and Number		10f. Zip Code	10g. Ci	itizen of What Country?
death with the Maryland rms 23e or 28e-1 show rmust be notified at		AVE.	上入し入入さ	3 (J.S.A.
Iter death with the Mar ritems 23e or 28e-1 et ther must be notified Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	 Race - American Indian, Black, White, etc.
urel; or	1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: / .) hiTE
2 hour	15. Decedent's Ed	ucation 16a. Dec	edent's Usual Occupation	16b. K	Kind of Business/Industry
of Min 72 ho ygiene. 1, the Medical Completed	(Specify only highest grad Elementary/Secondary (0-12)	(Given the completed) (Given the completed)	e kind of work done during most of wo DO NOT use retired)	rking	•
Sort the	6	HOL	SE PAINTER	Co	NSTRUCTION
be filed within 72 hours after tell Hygiene, dother then "neturel", or lie event, the Madical Examina Be Completed by Furnish	17. Father's Name (First, Middle, Last)	1	18. Mother's Na	me (First, Middle, Maider	*
Via nould I Men Men Men Men Men Men Men Men Men Men	EDWARD L. B	EALL	MARY K	L. PETER!	\$
2 sh and is merel	19a. Informant's Name/Relationship (T		ling Address (Street and Number or R	ural Route Number, City o	or Town, State, Zip Code)
C, I end 1 end 1 end 27 mm 27 ther t	JOAN HRNDT, 315 20a. Method of Disposition	TER 1322	WHITMANDR GEN		
Dallimore, Maryland 21213-0030 permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mentel Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-1 show any injury or other treumatic event, the Madical Enaminer must be notified at once. To Be Completed by Funeral Director	1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	ernatory or other place)		ocation - City or Town, State
calling	4 □ Donation 5 □ Other (Specify, 21. Signature of Fullers) Service Licens			6-06 HAN	loier, My.
Dentil. Departrimporte ony inje	M-20		2. Name and address of Facility Daugherty Family Funeral	Home And Cremation (Center PA
	23a. Part1. Enter the disea e. o comushock, or heart failure. List	mons that caused the death. Do not en	2601 Mountain Road atter the mode of dying, such as cardia	Pasadona MD 2	1122 Approximate
Physician	tmmediate Cause (Final			o or respiratory arrest,	Interval Between Onset and Death
/Medical	disease or condition resulting in death)	Methadone intoxication Due to (or as a consequence of):	1		
Examiner					
ne a	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a consequence of).			
cate be executed physicien end it the burial-transit dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	s			
e be ex sicien burial		Due to (or as a consequence of):			
icate be physicie s the bur		d			
The law requires that the death certific set has been signed by the attending page 2 should be detached for use as completed by Physician/Mee	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			and Date of deliver
Jeath Jeath Joru	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
het the cid by the stetached	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown			
res that signed to be delta	Part II. Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?
w require been sig should b				1 ☐ Yes 2	No 3 Probably 4 □Unknown
The law requirements the second of the secon				24a. Was an	24b. Were autopsy findings available
The law the hes bege 2 s				autopsy performed?	prior to completion of cause of death?
ysicien: The is certificate he director, page	25. Was case referred to medical examiner?		26. Place of De	A Yes 2 No ath Check only one	1 1 105 2 100
hysic his ce i dire	1X Yes 2 No	fospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other: 4 Nursing H	fome 5 Residence	expenser (Specify) Scene
ding Ph After thi funeral	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how injur	
tendin death. tor: Aft the fun	2 ☐ Accident investigation 3 ☐ Suicide 6 ☒ Could not be	Fnd 3/31/2006 Fnd 9:		unk	
tel or Attending Fis elter death. al Director: After ed in by the funer: Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street and City or Town, State	nd Number or Rural Route Number, 400 Millington Ave.
pital purs evai [20a Codding 1 Codificing Db	Found: residence		partimore, MD	
To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director; Affer this cartifice completely filled in by the funeral director, I Medical Certification; To Be C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, dea ner: On the basis of examination and/or in and manner stated.	in occurred at the time, date and place ovestigation, in my opinion, death occu	 and due to the cause(s) urred at the time, date and) and manner as stated. d place, and due to the cause(s)
To the comple	29b. Signature and title of certifier	0	29c. License number	29d. Da	te signed (Month, Day, Year)
7.	May mo	a Clarle un	OCME		pril 1, 2006
July 1	30. Name and address of person who co	empleted cause of death (Item 23a) (Type	, Print)		
1002	MARYARTS A	· K DRELL		Baltimore	, Maryland 21201

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 35 PM (MMN) Burton 5 + 2001/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 28, Bel AIR Health 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Virginia Director 101 Yrs. 578-24-9251 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Harford Bel Air Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21014 933 Jackson Boulevard filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Completed by 3 → Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth eny liqury or other traumatic event ang. Be Sarah Catherine Long Ander Hash ၉ John 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 933 Jackson Boulevard, Bel Air, Maryland 21014 Marian Burton Ely/Daughter Baltimore, 20a. Method of Disposition

1X Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Baltimore, Maryland Gardens of Faith 04-07-06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009
Inter the mode of dying, such as cardiac or respiratory arrest, Approximate (usell 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death detached Ö 9 Hokoowa 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available for to completion of cause of death?

1 Yes 2 No has autopsy performed? certificate 1 ☐ Yes 2 ☐ 1√0 Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient ٩ 1 Yes 2 → M6 2 ER/Outpatient 3 DOA of this 28a. Date of Injury (Month, Day Year) To the Hospital or Attending P? within 24 hours efter death.
To the Funeral Director: After the completely filled in by the funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1-Natural 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's State APR 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician narles 31d April 000 /Medical 4a. Fecility Name (If npt institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Itoward county General hospital HOW Columbia If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 395-18-3717 Director June 13,1920 Wisconsin 85 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, 112 Medical Examinar must be notified at 1 Yes 2 No Ellicott City Director Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21042 9410 Joey Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Distilling 5+ Civil Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental Heart: If item 27 Is marked of Charles Belik Lilyon Sedlacek ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9410 Joey Drive; Ellicott City, Maryland 21042 Wife Barbara R. Belik 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or John's Cemetery 4/8/2006 Ellicott City, MD Injury 22. Name and Address of FacilitySterling Ashton Schwab Witzke 21. Signature of European Se Funeral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsville, is ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory agrest, fure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1. Enter the dis shock, or heart fair Immediate Cause (Final (on on any **Physician** disease or condition resulting in death) /Medical Examiner cor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed burial-transi P.O. Box 68760, Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ should be 2 No 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 certificate 2/No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 20 2 ER/Outpatient 3□ DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 5 Pending 1 Natural Injury 4 hours after death. Funeral Director: A death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicef Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of entitier 29c. License number 150870 30. Name and address of person who completed cause of deathfillem 23a) (Type, Print) SNZan Abdo 5005 SIGNOW Bell Lank Clarksulle MD 21029 31. Date filed (Month, Day, Year, State

DHMH 17 Rev 1/2001

Registrar

of Maryland / Department of Health and Me	ental Hygiene	10866
Certificate of Death	Reg. No.	10000

			1-	For State Registrar		State of M	arylan			nt of H te of L		Ment		iene g. No.	in the the the	10866
	Physici /Medi		1. D	ecedent's Name	(First, Middle, Las LEROY	.t)		ВА	SS				RTL 4	Day	006 Year	3. Time of Death 3:22 P M
	Examir Funeral			4249 LA ocial Security Nu	BYRINTH F		pe (In yrs. I	ast birthday)		B er 1 Year	ALTIMORE If Under 24 Hrs Hours Min.	8. Da	ate of Birth		9. Bir	N/A thplace (State or Foreign
	Director		-	216-32- al Residence of	Decedent	X	6					MA	R.7,1	937		עוויי
	Marylan a-f ehow	tor	10a.	State	10b. County N/A		10c. City	y, Town or La BAL	TIMO	RE						10d. Inside City Limits 1
	h with the 23a or 28a	Funeral Director	10e.	Street and Num		ROAD			10f. Z	ip Code	2121	5	10	0g. Citi	zen of What Co	ountry? USA
980	be filed within 72 hours after death with the Maryland hal hygiene. of other than "neturel", or Iteme 23a or 28a-f ehow event, the Madicial Examinar must be notified at		1	Marital Status Never Mame Widowed	ed 2 💢 Married 4 □ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 ☐ If Yes, Give Year or Dates:				edent of Hi ecify Cuba 2 X No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Y to Rican	res or No-		14. Race - Ame Black, White Specify:	
21215-0036	d within 72 ho giene. Ir than "netur Ine Medical	Completed by	E	(Speci ementary/Secon	15. Decedent's Ed fy only highest grandary (0-12)	ucation de completed) College (1-4or	5+)		dent's Us kind of w DO NOT PRIE	ork done d use retired	ation luring most of wo	rking			nd of Business	-
Maryland 2	should be filed within and Mental Hygiene. Is marked other than eumatic event, the Man	To Be C	17. f	EMANUEL	First, Middle, Last)			BAS	S		18. Mother's Nar ROSE	ne (Firs	t, Middle, N	Aaiden		GURALNICK
	2 £ 2 5		19a		me/Relationship (7				-		and Number or Ru			-		
Baltimore,	Page net o int: If					Removal from State	C	lace of Dispo emetery, crer	natory or	other plac		Date 4/6/			Cation - City or	
Balt	permit. Pag Department Important: eny Injury once.		21.	Signature of Fur	neral Service Licen	T. att	the	1								., INC.
ĵ	Physician /Medical Examiner	er	Imn dise rest	nediate Cause (I ease or condition ulting in death)	Final	a. Metast Due to (or as	a consequ	Nonsimuence of):			g, such as cardiad			est,		Approximate Interval Between Onset and Death 3
68760,	ificate be executed g physician and as the buriel-transit	edical Examiner	Cau Cau that resu	uentially list con ly, leading to im se. Enter Under se (Disease or i initiated events ulting in death) L	tying njury ast	cDue to (or as	a consequ	uence of):								
O. Box	The law requires that the death certifule has been signed by the attending tage 2 should be detached for use as	Physician/Me		EMALE: . Was decedent in the past 12 r 1 Yes 2 9	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic Other (s	pregnancy specify)				2	23d. Date of de Month	iivery Day Year
ords, P.	w requires thet been signed b should be deta		Part	11. Other signifi itered.	(entributing to death b	1	ulting in the un			en in Part I.	2	23e. Did tob			o the cause of death?
of Vital Records,		Completed by			J	•							24a. Was an autops perform	У	24b. Were a prior to death?	utopsy findings available completion of cause of
of Vita	Physician: 1 rthis certificel ral director, p	To Be		Was case referrexaminer? 1 ☐ Yes 2 🔯	1	Hospital: 1 ☐ Inpatie	ent 2 🗆 I	ER/Outpatien	t 3 🗆 C	Othe	26. Place of Dea				6 □Other (Spe	icify)
	ath. rr: Aftei re fune	ation;		Manner of Death Natural Accident	5 Pending investigation		y Year)	28b. Time of Injury	М	28c. fnjury Work 1 🗆 `	at ?? Yes 2 □ No	28d. C	Describe ho	w injur	y occurred	
Division	To the Hospital or Attending within 24 hours effer death. To the Funerel Director: Affer completely filled in by the fune	Certification;		3 Suicide 4 Homicide	6 ☐ Could not be determined	28e. Pface of In- building, et	ury - At ho c. <i>(Specif</i> y	ome, farm, str	eet, facto	ry, office		28f. Lc	ocation (Sti lity or Town	reet an , State	d Number or R)	ural Route Number,
(é	he Hosp in 24 hou he Funei pletely fil	Medicai	29a	. Certifier (Check only one)	1⊠ Certifying Phy 2□ Medical Exam	ysician: To the best liner: On the basis o and manner st	f examinat	wledge, death tion and/or inv	occurre	d at the tim n, in my op	e, date and place pinion, death occu	e, and du urred at t	ue to the ca the time, da	use(s) ate and	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Σ	29b.	Signature and	A 2	L.				9c. License				9d. Dat	e signed (Mon.	th, Day, Year)
-	b		30. 1	171151	Porth Schil	completed cause of o	death (Item	23а) (Туре,	Print)	10	hos		0	7	113/	(006
ž	Sta Registi		31.	Date filed (Mont		. Registr	rar's Signa	ture 1	W.	<i>ξ ['</i>	heserlle	, vn	<i>D</i>			

DHMH 17 Rev 1/2001

APR 0 7 2006

		State Registrar 1. Decedent's Name (First, Middle, L.		rtificate of Death		g. No.	3. Time of Deat
sicia ledica amine	in al	1. Decedent's Name (Pilst, Middle, L.		CARLO!	Month	Day Year 19, 2006 4c. County of Death	16:421
eral		5. Social Security Number 6. 169-44-9258	HOPKINS HISPIFAI Sex 7. Age (In yrs. last birthday 1 M 2 F 54 Yrs.	BALFINOLE If Under 1 Year If Under 24 H	7	N/a (7,1952 2 Con	pplace (State or For intry) PA
ac at		Usual Residence of Decedent 10a. State 10b. County Md	N/A 10c. City, Town or L				10d. Inside City Li 1 AYes 2 ☐
at be notif	Funeral Director	10e. Street and Number 535 N. Washii	ngton Street	101. Zip Code 212		g. Citizen of What Cou	untry? USA
9	<u>م</u>	11. Marital Status 1 ☐ Never Married 2☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 TNo If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt 1 ☐ Yes 2 ☒ No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White Specify: Bl	, etc.
Medical	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	rade completed) (Give	edent's Usual Occupation 9 kind of work done during most of DO NOT use retired) il Carrier	working	6b. Kind of Business/l	
c event, the Ms	Be	12th 17. Father's Name (First, Middle, Las Robert Boyer		18. Mother's I	Name (First, Middle, Mi A Rose Su	aiden Surname)	
r treumati	၉	19a. Informant's Name/Relationship Ronald L. C		ing Address (Street and Number or 35 N. Washing			
ury or othe		20a. Method of Disposition 1	□Removal from State 20b. Place of Disp cometer, cre King Me	annata an' ao astron ataona		oc. Location - City or T Randalls	
any Injury or once.		// /	vio	2. Name and Address of Facility (5240 Reisters	town Rd B	altimore	Md.212
cian lical		23a. Part 1 Enter the disease, or co shook, or hear failure. List on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death. Do not erly one cause on each line. a	ter the mode of dying, such as care	diac or respiratory arres	st,	Approximate Interval Betwee Onset and Dea
iner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):	duct cyst			11 year
s the burial-translt	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Yea
8	<u>آ</u>	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	the cause of deal
page 2	Completed				24a. Was an autopsy perform	ed? prior to c death?	topsy findings ava ompletion of caus 2 No
actor	To Be (25. Was case referred to medical examiner? 1 ™ Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatie	Other	Death (Check only one g Home 5 Pesider		ufv)
	Certification: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could	be 390 Place of Injury - At home farm of	Work? M 1 Yes 2 No	28d. Describe how	w injury occurred eet and Number or Ru	ral Route Numbe.
stely filled in b		29a. Certifier 1 Certifying I	Physician: To the best of my knowledge, dea	th occurred at the time, date and pl	City or Town,	use(s) and manner as	stated.
	Medical	(Check only 2 Medical Ex	aminer: On the basis of examination and/or is and manner stated.	nvestigation, in my opinion, death o		te and place, and due d. Date signed (Month	``
mpietely	> I			ESC. LICENSO HUMBON	1 23	a. Date signed (Month	, Day, I bai
completely	2	b distribution and time of controls	Mr. MD	D32641	M	larch 26	1001

			For State Registrar	State of Ma	ryland /	•	artment of H tificate of L			giene	6 10868
ı	Physici /Medic		1. Decedent's Name (First, Middle, Norman E. Cr						2. Date of De Aorth	Day	3. Time of Death 2006 0508 M
	Examin Funeral		4a. Facility Name (If not institution, SAINT AGN 5. Social Security Number	ES HEAU	HCA.		4b. City, Town, or BAC	TIMOI If Under 24 Hrs.	E Date of Bir	4c. County	of Death 9. Birthplace (State or Foreign
Ē	Director		218-09-3645	10XM 2□F 8	34	Yrs.	Months Days	Hours Min.	July 23		Country) Maryland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits
	Maryl	ţo	Maryland Baltim	ore	Cate	onsv	i 1 1 e				1 ☐ Yes 2 No
	h the or 28e	Directo	10e. Street and Number	.010	- Od E	0115 V	10f. Zip Code			10g. Citizen of W	Vhat Country?
	23a c		2 McIntosh Cou	rt Apt. E			21228			USA	
9800-91212	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturel", or iteme 23s or 28e-f ehow event, the Medical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? ad 1 XYes 2 □ N If Yes, Give Year or Dates: 1	lo	'	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2☑ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	Blac	e - American Indian, kk, White, etc. :: White
2	72 ho	eted	15. Decedent's (Specify only highest	s Education grade completed)	16	(Give	dent's Usual Occupa	furing most of wor	king	16b. Kind of Bu	usiness/Industry
2	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	OO NOT use retired achinist)		Commun	ications
	filed Hygi ther ant,	ပ္ပို	10 17. Father's Name (First, Middle, L	ast)				18. Mother's Nan	ne (First, Middle	, Maiden Sumam	
Maryland	should be nd Mental marked c	To Be	Christopher Cr	ouse				Marv	Ellen W	orsdell	
ary	2 should and he ls mail		19a. Informant's Name/Relationsh		1	9b. Mailir	ng Address (Street a				State, Zip Code)
	and ealth m 27		Normale Faith D	oyle Daugh			Hallam Co	ourt; Ba			
Baltimore,	Page nent o		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	ceme	o Cre	sition (Name of natory or other place ematory	4/8/	Date 2006	Catonsv	City or Town, State ille, Maryland
Ball	permit. Depertrimporte		21. Signature of Furnira Service L		2170	22	Name and Address	is of Facility St. Home of	erling <i>E</i> Catonsvi	ille,Inc	chwab Witzke •
	45200		23a. Part1. Enter the disease, or o	complications that caused	the death. D	0 116	30 Edmon	dson Ave:	nue; Cat	consville	e, MD 21228 Approximate
	Physician /Medical Examiner		shock, or hear tailure. List of immediate Cause (Final disease or condition resulting in death)	a.Type A	0		.c.c.c. A	-		A	Interval Retween
1	1	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	net	ce of):	Hore	+10	valv	٤	Unkerny
Ö,	icate be executed physicien end s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequenc	ce of):				·	
8760	cate b physic the b	dical		C.		-				all: 25	
O. Box 6	death certif e ettending od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery nth Day Year
rds, P	- v -	ρ	Part II. Other significant condition	ns contributing to death bu	it not resulting	g in the u	nderlying cause give	en in Part I.	23e. Did t	CA.	ribute to the cause of death? 3 Probably 4 Unknown
al Records,	The ete h page	Completed							24a. Was auto perfo 1 □ Yes	psy promed? p	Nere autopsy findings available prior to completion of cause of death?
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	· ·		. 3□ DOA Othe	26. Place of Dea		7777	
ō	Phy this rald	٠ <u>.</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	y 28t	Outpatien D. Time of	28c. Injury	at		dence 6 Other	
0	nding f ath. r: After e funer	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Day	Year)	Injury	Work	k? Yes 2 □ No			
Division of	Hospitel or Attending 44 hours after death. Funeral Director: After tely filled in by the fune	Certification;	3 Suicide 6 Could no 4 Homicide determine		ry - At home, . (Specify)	, farm, str	eet, factory, office		28f. Location (City or To		er or Rural Route Number,
	To the Hospitei within 24 hours a To the Funeral completely filled	Medicai (29a. Certifier 1 Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examination	dge, death and/or in	occurred at the time vestigation, in my op	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
)	To the To the comp	Ž	29b. Signature and title of certifier	7 7m	\sim		29c. License	number 7 0 2 7	3151	29d. Date signed	(Month, Day, Year)
_	5+1		30. Name and address of person w	tho impression cause of de	MIV	N V	700	Agne	, Ho	sport	al
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	Signature	for	N. C. C. C. C. C. C. C. C. C. C. C. C. C.	U			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year 5 ANNA DICKERSON APRIL 2006 10:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) 87 Yrs. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Mayorth 103y, Yenro18 9. Birthplace (State or Foreign New York **Funeral** 070-12-0659 1 ☐ M 2 💢 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show in than "natural", or items 23a or 28a-f shows the Medical Examiner must be notified at by Funeral Director Maryland Frederick Frederick 1X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? U.S.A. 10f. Zip Code 5777 Box Elder Court 21703 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 X Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) U. S. Government Accountant treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be filment of Health and Mental Hant: If Item 27 is marked oth jury or other treumatic even Willis Root Stella A. Leclair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16705 Elmer School Road, Dickerson, MD 20842 Mary Jane Poole/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) artment c Arlington National Cemetery April 27, 2006 Arlington, VA Departition of the post of the 21. Signature of Figneral Service J 22. Name and Address of Facility Keeney & Basford Funeral Home 106 Fast Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** day /Medical Due to (or as a consequence of Examiner te Gas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and i be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Certification: To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 4a. Was an Was ari autopsy performed? Yes 2 No Hypertention
25. Was case referred to medical examiner? 1 ☐ Yes the funeral director, 26. Place of Death / Check only one 1 ☐ Yes 2 No Hospital: 1 X Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral [1x Certifyin 2 Physicien: To the best of my knowledge, duath because at the time, date and place, and dua to the cause(s) and industrial stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21944 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) i0FREDERICK, MB. 1475 TANEY AVE #204 31. Date filed (Month, Day, Year) 32. Regištrar's Signature State Registrar 2006

			1 - State of Marylar	nd / Depa	artment of H	lealth and N	Mental Hygi	ZUUb	10870
			1 - State Registra Amend Item #17 Per FH C85 1. Decedent's Name (First, Middle, Last)	4 4/17	106 a 11 Or 1	Dealli	2. Date of Death	g. Nő.	3. Time of Death
* *	Physici	an					Month	Day Year	5:45 PM
	/Medic		Betty D. Davis 4a. Facility Name (If not institution, give street and number)		4b City Town or	Location of Death	April	6 , 2 0 0 6 4c. County of Death	
1	Examin	er	6700 C Overton Court Apt 3	12	Freder				
Fq.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Frederic 9. Birth	place (State or Foreign intry)
	Director		219-18-2260 1 M 2 MF 84	Yrs.	Months Days	Hours Min.	(Month, Day, 1 3 / 6 / 1 9		intry)
	P		Usual Residence of Decedent					Charles	
	ahow		10a. State 10b. County 10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Ba-f a	cto		ederi					1 ☐ Yes 2 📝 No
	hours after death with the Maryland turel', or Items 23e or 28e-f show at Executor mast be notified at	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?
	s 23s	Funeral	6700 C Overton Court Apt		2170			USA	
	er de Item	nu	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.5. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ₺ No If Yes, Give 3 ₺ Widowed 4 ☐ Divorced Year or Dates:		1☐ Yes 2☐WNo	Specify:		Specify:	4+0
21215-0036	72 hours 'natural', dicel Exp		15. Decedent's Education	16a. Dece	dent's Usual Occup	ation	11	6b. Kind of Business/li	ıite ndustry
715	⊆ 2	ple	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of world)	ring		
21	72 12 14 14	Completed	6	Soci	al Case	Worker	s ·	tate of C	klahoma
b	be filed tal Hygi d other event, I	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M.	aiden Sumame)	
yla		ို	Jackson Davis William Do	ckhorn		Mert1	e Porte:	r	
Maryland	and le m	11.5	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, Zi	p Code)
	s 1 and if Health Item 27 other tr		Timothy P. Davis Son	6334	Lysand	er Cour		rick MD 2	
Baltimore,	T S T		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	Place of Dispo cemetery, cre-	osition (Name of matory or other place		Date 2	0c. Location - City or T	own, State
Ë	Pag ment tant:		4 □ Donation 5 □ Other (Specify) S m	ithsb	urg Cre	m. 4/8	/2006 Sr	ithsburg	, MD
Sall	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lead ee	22	2. Name and Address	ss of Facility K e	eney & J	Basford P	.А. Г.Н.
_	40 = 9 a		John Co XMare	1	06 East	Church	Street	Frederic	k Md 2170
			23a Parti Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.	th. Do not ent	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition assure or condition	sece	MOTIC CA	NOIDNA	sum	DISEASE	1542>
	/Medical Examiner		resulting in death) Due to (or as a consecutive conse						
	A CO		Sequentially list conditions, b. Due to for as a consecution of the conditions of th	300	SION				20425
\mathcal{T}	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	trieuce or):					
	be executed Ician and burial-transit	xan	that initiated events c	quence of):					
190	ite be executed lysician and he burial-transit	calE	· ·	,					
687	# × 6		d						
×	death certificat e attending phy of for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregn	ancy				23d. Date of deliv	(ALV
Вох	atter I for u	clar	1 ☐ Live birth 2 ☐ Feta in the past 12 months? 4 ☐ Pregnant at time of 0		□Ectopic pregnancy □ Other (specify)			Month	Day Year
o.	at the de by the a tached	lys	9 Unknown 9 Unknown						
<u> </u>	de de	by Pt	Part II. Other significant conditions contributing to death but not re-	sulting in the u	inderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
of Vital Records,	n sign		AMIN GIBRILLATION				1.☐Yes	2 □ No 3 □ Pro	bably 4 Unknown
CO	w require been si should I	Completed	CHAONIC OBSTRUCTUE PO	المصداك	van.	111 : :-	24a. Was an	24b. Were aut	opsy findings available
Re	The lavate has	mc d			1111	136036	autopsy	ed? death?	ompletion of cause of
ta		Ö	OSTROPUNOS IS 25. Was case referred to medical			26 Place of Dea	1 ☐ Yes 2 th (Check only one	No 1 Yes	2 L No
>	Physician: this certific ral director,	0 0	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	05		ice 6 Other (Spec	(fv)
0		n T	27. Manner of Death 28a. Date of Injury	28b. Time o Injury		y at	28d. Describe hov		• • • • • • • • • • • • • • • • • • • •
0	Attending I r death. ector: After by the funer	atlo	1. ■Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		Yes 2 □No			
Division	of or Attend efter death Director:	₽ 1	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At h building, etc. (Speci	ome, farm, st	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Rui	ral Route Number,
	s efter s efte	Certification:	Sulfaring, stor (special				ony or roun,	olato)	
	Hospitel or At 24 hours efter o Funerel Direct etely filled in by	ledical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner	owledge, deat	th occurred at the tin	ne, date and place,	and due to the cau	use(s) and manner as	stated.
	within 24 To the F complete	Med	and manner stated						
	To To		29b. Signature and title of certifier		29c. License			d. Date signed (Month	, Day, rear;
			· Unit /h. offine	, mg		002881		417/06	
	12		30. Name and address of person who completed cause of death (Itel		*	Tarre	iow, MI	0 2120	./
	Sta	te.	7801 YORK ROAD 31. Date filed (Month, Day, Year) 32. Figistrar's Sign	ature	102	1000	ON , 111		7
	Registr		APR 0 7 2006	N A	3000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ethel May Durrett APRIL 5 01:36A M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov. 7, 15 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2**X** F Months Days Hours Min. 213-03-2405 Director Maryland Usual Residence of Decedent Show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is markad other than "natural", or items 23e or 28e-f shov treumatic event, the Modical Exercise method sit 1 ☐ Yes 2 🛛 No Director Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3366 Belmont Ave. 21136-3832 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert E. Smith Smith Ethel Marie and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nent of Health a int: If item 27 is George Durrett/husband 3366 Belmont Ave., Reisterstown, MD. 21136–3832 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State in ury or '4 □ ponation 5 ☑ Other (Specify)Entombment

21. Signifure of Furtural Service Licensee Dulaney Valley Mem. 04/10/2006 Timonium, Marvland 22. Name and Address of Facility Ruck Towson Funeral Home. Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1050 York Road, Towson, Maryland 21204 Approximate Interval Between Onset and Death Immediate Cause (Final Intra cerebral hemorrhoge Physician hour disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): the attending physician Physician/Medicai the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Aspiration 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DARUMONIA certificate has autopsy performed? 2□ No 1 ☐ Yes 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death Check onl one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident investigation Director: 3 🗍 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760, P.O. Division of Vital Records, Hospitel or Attending death. To the Hospitel within 24 hours at To the Funerel D

Itimore, Maryland 21215-0036

29b. Signature and title of certifier

State Registrar

marie Chartan

6701 North Charles St.

29d. Date signed (Month, Day, Year)

D20907

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chatham

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Marie 31. Date filed (Month, Day, Year)

32. Registrar's Signature

(Check only one)

20

		For State Registrar	State of Marylan		ent of Health and I	Mental Hygier	4000	10872
Physic		1. Decedent's Name (First, Middle, Las	EHA T			2. Date of Death Month	S 2006	3. Time of Death
/Med Exami		4a. Facility Name (If not institution, give		11.00	ty, Town, or Location of Deall BALTIMORE	1,1	4c. County of Death	
Funeral Director		205-80-16-51	7. Age (In yrs. I	Month	der 1 Year If Under 24 Hrs. ns Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Cou	nplace (State or Foreign untry) RYLAND
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location	D. David			10d. Inside City Limits 1 Yes 2 No
death with the Maryland ms 23s or 28s-f show runnt be notified at	Funeral Director	10e. Street and Number	ROLLEY C	10f.	Zip Code	10g.	Citizen of What Cou	untry?
		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, s	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	
Ind 21215-0036 be filed within 72 hours after tal Hygiene. d other then "natural", or lie event, the Mudical Examilia	leted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed (Specify only highest grade)	Year or Dates:	16a. Decedent's U	sual Occupation work done during most of wo.	rking 16b	. Kind of Business/li	NITE ndustry
d 2127 filed withir Hygiene. other then ent, the M	e Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Summing	Pool INSTALL	TR C		CITION
Maryland 2 should be file th and Mental Hy 7 is marked oth traumatic event	To Be	EDMUND EAT	TJR	10b Mailine Adds	ass (Street and Number or Ru	KISTNE	R	in Code)
M2		EDMINE AT JR	FATHER	7250 Tu	ANACEBE RO	GENBUR	Location - City or 1	10la
Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	ANA	Place of Disposition (I emetery, crematory)	REGISTRY 41-1		NOVER I	
Balt permit. Departr importa		21. Signature of Fineral Service Licen		Da	and Address of Facility augherty Family Funeral I 2601 Mountain Road	- Pasadena, MD.		
Physician		23a. Part I. Enter the disease or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition		Do not enter the m	_	or respiratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a consequence of the BACTER)	uence of):	UDOCARD	PITIS		
and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CDue to (or as a consequence.					
18760, craft in the properties of the purial-transit	dicai	(d	dence or,				
Box 6 auth certif	Physician/Me	in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of di	I death 3 ☐ Ectopic	c pregnancy (specify)		23d. Date of deliment	very Day Y <i>e</i> ar
IS, P.O. res that the de iigned by the a	by Phy	9 ☐ Unknown Part II. Other significant conditions of		ulting in the underlyin	g cause given in Part I.	23e. Did tobac		the cause of death?
Records,	Completed					1 🗌 Yes 24a. Was an		topsy findings available completion of cause of
	O O	25. Was case geterred to medical			26. Place of De	autopsy performed 1 ☐ Yes 2 ☑ ath Check only one	? death?	2 No
Of Vita g Physician: er this certific eral director,	n: To B	examina 7 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	28b. Time of	Other	Home 5 ☐ Residence		cify)
Division of Vita to a variending Physician: after death. Director: After this certification by the funeral director.	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - Al ho	Injury M ome, farm, streel, fac	1 ☐ Yes 2 ☐ No	28f. Location (Stree		ral Route Number,
는 호텔 등 드		29a. Certifier 1 Certifying Ph	building, etc. (Specification) ysicien: To the best of my kno	y) owledge, death occur	ed at the time, date and plac	Gity or Town, S	e(s) and manner as	stated.
To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	(Check only 2 Medical Examone) 29b. Signature and title of certifier	iner: On the basis of examina and manner stated.	ation and/or investigat	ion, in my opinion, death occ 29c. License number	urred at the time, date	and place, and due Date signed (Monti	to the cause(s)
) F S F 3		Fedral Saly	in		D31993 2256			
Y		30. Name and address of person (m)	BOLGIONO		22 S. G.	Teene St	- Bal-	timore
S Regis	tate : trar	31. Date filed (Month, Day, Year) APR 0 7 200	7. Registrar's Signa	Super Control	•			

06-02327 Please Type or Print in Black Indelible Ink Foster, Cynthia State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day April 4, 2006 Medical Examiner 16:50 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3910 Fordleigh Road Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) g/Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Months Days Hours Director M 2 X F Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 XYes 2 No iten 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. Maryland
10e. Street and Number hours after death with the Maryland mor Director 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Noecedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Divorced If Yes, Give Year 1 Yes 2 No specify: Widowed ş or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) Health Care **Baltimore, MD 21215-0036** 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (mother) If item 27 is Mad Salto, 11/d, 2/2/ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State or other crematory or other place) X Burial 2 Cremation 3 Removal from State 2006 mportant: butus Mem. Park Other Specify: Donation 5 22 Name and Address of Facility 21. Signature of Funeral Service Licensee, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Retween Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit the Hospital or Attending Physician: The law requires that the death certificate be executed X AMENDED certificate has been signed by the attending physician ector, page 2 should be detached for use as the burial -UNPENDED item# 16b perFH, G854, 4/7/06 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed' death? Yes 2 V N 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Other Nursing Home 5 Residence 6 Other: Scene Inpatien 2 ER/Outpatient 3 DOA After this 1 Yes 2 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural d in by the f 1 Yes 2 No Pending Investigation Accident completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. April 6, 2006 30. Name and address of person who completed deuse of death (Item 23a) Assistant Medical Examiner Theodore King MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Figistrar's Signature State APR 0 Registrar 7 2006 DHMH 17 Rev 1/2001 **ORIGINAL**

WILL	LIAM A.	FR	AZIERnpend ite 1- State Registrar	em# 23a,	27, 28a-f State o	r Mary		4/12/0 epartme Certifica					giene	00	6	108	74
			Decedent's Name (Fire	st, Middle, Last)			-				2. Date of De				3. Time ot	Death
_	Physici		WILLIA	AM A		FRAZI	ER					MARCH MARCH	$\begin{bmatrix} 24 \end{bmatrix}$, 20č	6 ear	1932	РМ
	/Medi Examir		4a. Facility Name (If not it	nstitution, give	street and nu					or Location of			4c.	County of	Death		
	Funeral Director		5. Social Security Number 233-86-513	7 15	x XIM 2□F		n yrs. last birtl	mday) ff Und Month	er 1 Year s Days		24 Hrs. Min.	8. Date of Bir (Month, Da Aug. 2	th ay, Year) 5, 19	54	Birthpl Count WV	ace (State o	r Foreign
	and w		Usual Residence of Dece 10a. State 10b.	. County		10	c. City, Town	or Location							10	Od. Inside Ci	ty Limits
	Mary	ō	WV I	Logan			Moun	t Gay								1 🗌 Yes	2 🔀 No
()	28.	rec	10e. Street and Number	108411			110 411		Zip Code				10g. Citi:	en of Wh	at Count	try?	
18	3a o	Funeral Director	PO Box 793					2.	5637				US	A			
Jax.	death	Jer	11. Marital Status		12. Was Dec	edent Eve	r in U.S.	13. Was Dec	edent of h	lispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.))-	4. Race -			
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital hygiene. A cother than "naturel", or Items 23a or 28a-1 show event, the Mudical Examinar must be notified.	by	1 Never Married 3 Widowed 4 D		1 ☐ Yes It Yes, Gir Year or D	2 (2) No ve				Specify:		rican, etc.)		Specify:	White, e Whit		
15-0	"natu	Completed	15. l (Specify on	Decedent's Edu ly highest grad	ucation le <i>completed</i>)		16a.	Decedent's Us Give kind of V life. DO NOT	ual Occup vork done	ation during mos	st of work	ing	16b. Kir	d of Busi	ness/Ind	lustry	
121	e filed within 72 at Hygiene. other than "nat	mo	Elementary/Secondary	(0-12)	Coflege (1-4or 5+)		aborer	use retire	<i>a)</i>			Con	stru	ctio	n	
d 2	filed Hygid Sther ent, I		12 17. Father's Name (First,	Middle, Last)			1.1	aborer		18. Mothe	er's Nam	e (First, Middle	_			11	
an	Mental Merked o	To Be	Ottis Frazi	ler								a Tomb					
Ž	permit. Pages 1 and 2 should be Depermit. Pages 1 and Menta Depertment of Health and Menta Important: If Item 27 is marked eny injury or other traumatic evonce.	F	19a. Informant's Name/F	Relationship (T)	vpe, Print)		19b.	Mailing Addre	ss (Street	and Numbe	er or Rur	al Route Numb	er, City or	Town, St	ate, Zip	Code)	
Z	ad 2 27 le		Emmett Fraz	zier -	Brother	r						an, WV	256				
ā,	t Hear Hear Hear Othe		20a. Method of Disposition	on		1	20b. Place of cemeters Barlow					Date	20c. Lo	cation - Ci	ity or Tov	wn, State	
SE.	Page ent o nt: If		1 ☐ Burial 2 ☑ Cre 4 ☐ Donation 5 ☐			State	Barlow Cremat	Bonsa	11		3/30	/06	Char	lest.	on.	WV	
量	ortal		21. Signature of Funeral				Cremat		and Addre			llins F				***	
ñ	Per Per Per Per Per Per Per Per Per Per		fa 5	7) Box 3				WV 2	5647
	Dhysisian		23a Part1. Enter the dis shock, or heert fall tmmediate Cause (Final						ode of dyir	ng, such as	cardiac	or respiratory a	rrest,			Approximate Interval Bett Onset and I	ween
1	Physician /Medical		disease or condition resulting in death)		a		toxicati onsequence o										
	Examiner						,	,									
		Jer	Sequentiafly list condition cause. Enter Underlying Cause (Disease or injury that initiated events	ns,	b. Due to	(or as a co	onsaguence d	ŋ:			***						
	te be executed ysician and ie burial-transit	Examiner	Cause (Disease or injury that initiated events		c												
ó	e exe ian au urial-t		resulting in death) Last		Due to	(or as a co	onsequence o	f):									
3760,	ate be nysici	Cal			d										-		
89	ing pt	Med	fF FEMALE:	- 1													
Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	23b. Was decedent preg in the past 12 mont	mani		ointh 2	Fetaf death	3 Ectopic		у			2	3d. Date of Month		-	Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkn	nant at tim own	e or death	5 Other (sреспу)								
P.0	thet ted by		Part II. Other significant	conditions co	ntributing to d	eath but n	ot resulting in	the underlying	cause giv	en in Part I	1.	23e. Did	obacco u	se contrib	ute to the	e cause of d	leath?
Division of Vital Records,	w requires that s been signed to should be deta	d by										10	Yes 2	No 3	Proba	ably 4 🗆	Jnknown
03	w req beer shou	lete										24a. Was	an	24h We	re autor	sy findings	available
Re	iician: The lav certificete has rector, page 2	Completed										auto	psy prmed?	prid dea	or to com	npletion of c	ause of
a	in: Ti ificete or, pa	ပိ	25. Was case referred to	medical						OO Disease		1 Yes		1 5	Yes	2□ No	
Ξ		00	examiner? 1X Yes 2 No		Hospital:	Innationt	2 ER/Out	nationt 2 1	Ott			h (Check only one 5 ☐ Resi		Xiothar	(Casa h	AT S	CENE
ō	Phys or this oral di): To	27. Manner of Death		28a. Date	of Injury	28b. T	me of	28c. Injui Wor		ursing no	28d. Describe) AL D	<u>Оши</u>
on	th. : Afte	it or	1 □Natural 5 [2 □ Accident	Pending investigation		ith, Day Ye 124/200	$\frac{1}{26}$ Fnd $\frac{1}{7}$	25 PM		rk? Yes 21 √ []	No	unk					
/isi	Atter dea	flea	3 ☐ Suicide 6 🛭	Could not be determined	28e. Place	of fnjury	- At home, far		ory, office			28f. Location (City or To	Street and	Number	or Rural	Route Num	ber,
á	al or after i Dire	Certification:	4 Homicide		house	ing, etc. (S	Specity)					Westminst	wn, State, ter. M	D 1105	Sing	er Dr.	
	To the Hospital or Attending Physimithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical (29a. Certifier 1 (Check only one)	Certifying Phy Medical Exami	iner: On the b	e best of m easis of examer stated	amination and	death occurre or investigation	ed at the tie	me, date ar opinion, dea	nd place,	and due to the	cause(s)	and mann	ner as sta d due to	ated. the cause(s)
_	Fo the vithin Fo the complex c	Me	29b. Signature and title of	of certifier	/ 0			2	9c. Licens	se number			29d. Date	signed (Month, L	Day, Year)	
	C > F 0		> Would	me 1	me U	sull	M		0.0	C.M.E			MAI	RCH	25,	2006	
_			30. Name and address o	f person who o	ompleted caus						TIMOI	RE,MARY					
	Str	ate	31. Date filed (Month, Da	ny, Year)	La		0:										
	Regist		APR 0		المائلا	2	Signature	orthe)									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** APRIL 2006 1:20 P ANNIE LORRAINE GIORDANO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ANNE ARUNDEL 508 DELMAR AVE. GLEN BURNIE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Yrs Director 79 NOV 8, NC 214.22.1273 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show in then "naturel", or items 23a or 28a-f sho the Wedical Exeminar must be notified at 1 ☐ Yes 2 ☐ No XX Directo ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 508 DELMAR AVE. 21061 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes YM No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ₹₩idowed 4 Divorced WHITE XXCompleted Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER OWN HOME 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic even <u>once</u>. Be ANNA TYSON WILLIAM HUFFMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DAUGHTER 508 DELMAR AVE. GLEN BURNIE, MD 21061 LAURA J. HERNANDEZ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State `4 Donation 5 Other (Specify) MD VETERANS CEMETERY 4.5.2006 CROWNSVILLE, MD 21. Signature o Funeral Service Licenses 22. Name and Address of Facility
FINK FUNERAL HOME, P.A. GREGORY FINK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 23a. Part. Enter the lises e, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in douth) BCELL LYMPHOMA IMETASTATIC **Physician** 6 WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner It any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown Completed HYPER TENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 🗆 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No Certification: To 4 Nursing Home 5 ★ esidence 6 Other (Specify) his Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide To the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D18362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto. Ndzizza k. Dang Ave. Suite 308. 3455, M.D. Wilkens 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 0 7 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, perFH 5854,4/24/06 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2006 **Physician** April 5, 2:06 PM M Vivian Z. Glinowiecki /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore 2040 Eastern Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5**218**42641968 mber **Funeral** Months 1 □ M 2 X F 01/04/1929 216-20-3766 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2040 Eastern Avenue 21231 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Completed by 3 Widowed 4 ☐ Divorced White Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stanislaus Zaleski Marcella Slebzak 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9654 Dixon Avenue Baltimore, Maryland 21234 Gregory Glinowiecki / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages I Department of P Important: If ite any injury or ot ouce. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Heart of Jesus 04/07/2006 Baltimore, Maryland Signature of Funeral Se 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 23a. Part1. Enter the dispuse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final punccentu disease or condition resulling in death) CUNIT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medicai 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner slated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signalufe and title of certifier 41612006 ~10 D40854

within 2

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

the Maryland

item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

and Mental Hygiene.

Physician

burial-tran

attending physician for use as the buria

ed by the a

After

Director:

24 hours a

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year) APR 0 2006



ORIGINAL

Paul Place

Buldmore

या २०३

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2006 **Physician** ames /Medical 4c. County of Death
Bulti 4b. City, Town or Location of Death (street and number) Examiner tome owson inore. Age (In yrs. last birthday) If Under 24 Hrs. Sex 1 X M 2 ☐ F 9. Birthplace Country) **Funeral** 3 Days Hours Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location or itema 23a or 28a-f ahov treumatic avant, the Medical Examiner must be notified at 1 Yes 2 □ No Completed by Funeral Director more 10g. Citizen of What Country? ચાચાડ t037 ISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
IVYes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 1☐ Yes 2 No Marylahd 21215-0036 Specify: 3 Widowed 4 □ Divorced Dlac. "natural", 16a. Decedent's Usual Occupation (Give fund of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. ay (0-12) College (1-4or 5+) ainter and 2 should be σWI 4108 item 27 20a. Method of Disposition Pages ' Depertment of Important: If its any injury or o 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State 21. Signature of Fure al Seption Libens Green Ustown MD 21133 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cancer **Physician** UNG Months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner dany, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attanding Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, cete has been sign, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2. No 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 🔁 No Certification: To 1 Tes 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) NOSPICE 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 □No within 24 hours efter death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26303 2006 APRIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATTIMORE NO 6601 AARON CAHLUES 1/ mO Chrles 32. Registrar's Signature 31. Date filed-(Manth, Day, Year) Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year William D. Hollar,Sr. 3, 2006 10:00 PM M April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 18 M 2□F Months Days Hours 87 Yrs. 142-10-0167 Director 05/03/1918 ΦН Usual Residence of Decedent 10b. County 10c. City, Town or Location in then "natural", or items 23s or 28s-f show the Medical Exempler must be notified at 10d. Inside City Limits 1 Yes 2 No Director MD Harford Bel Air 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 322 Huntsman Ct. 21015 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Specify. White 3 ☐Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Chemical Production ie marked other than Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 Factory Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orie W. Hollar Margaret Prugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health Hollar, Jr. William D./Son 322 Huntsman Ct. Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If Ita any Injury or ot Apr 6 1 ☐ Burial 2 Scremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Beltsville, Maryland Chesapeake Crematory 3006 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. - Ine Ritter MO1443 8717 Green Pastures Drive Baltimore, Maryland Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Complet 24a. Was an 24b. Were autopsy findings availa le prior to completion of cause of death? certificete 2 X No 1 ☐ Yes 2 ☐ No Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division To the Hospitel or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Chack July one) 29b. Signature and title of certifier 29c. License numbe. 29d. Date signed (Month, Day, Year) odle MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William 31. Date filed (Month, Day, Year) State APR 0 7 2006 Registrar

liam#800453863

LINDA HOFFMAN

more, Maryland 21215-0036

APRIL 5, 2006 4:20 a.m.

)	Division of Vital Records, P.O. Box 68760,		Balt
of.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician /Medical Examiner	permit. Departr Importa eny Inju
	Madical Carellinoston: To De Completed by Dhysician/Modical Everying		

Funeral Director

	Registrar						OGIL	ificate	OI DU	G (77		Reg. N	lo.				
1. 1	Decedent's Nam	e (First, Midd	dle, Last))							2. Date of I Month		ay	Year	3. Time of Death		
	inda Lee	e Hoff	man								April	5,	2006		4:15 AM		
	. Facility Name (i	If not institution	on, give	street and nu	ımber)			4b. City, To	wn, or Loca	ation of Death	_	4	c. County o	f Death			
S	tella M	aris H	lospi	.ce					Tim	onium		В	altim	ore			
5. 8	Social Security N	Number	6. Sex		7. Age (I	In yrs. last b		If Under 1 Months E		Jnder 24 Hrs. ours Min.	8. Date of 8 (Month,	Birth Day, Yea	r)	9. Birtho	place (State or Forei		
	20-72-3		1 1 5]M 2.02 x 0 [±]	4	8	Yrs.		,,,		03/11			_			
	sual Residence o					0- 01- 7-									od balda Obalda		
	a. State	10b. Count	ty		10	Oc. City, To	WIT OF LOCA	ation							10d. Inside City Limi 1 ☐ Yes 2		
MI 10e	D	Balt	imor	e		Phoen	ix								1 1 105 200		
106	e. Street and Nu	mber						10f. Zip Ci	ode			10g. C	Citizen of W	hat Cour	ntry?		
	4123 Sur	nnybro	ok R	oad				2113	1			Uni	ited S	State	es		
11.	. Marital Status			12. Was Dec Armed Fo	edent Eve	er in U.S.	13. W	as Deceder	nt of Hispan	nic Origin? (S exican, Puert	pecify Yes or i	No-		- Americ	can Indian,		
	1 Never Marr	ried 2□ Ma	arried		2 210 0			yes 2 ⊅	_	pecify:	, , , ,			, ************	oto.		
	3 Widowed	4 Divorce	ed	Year or D	Dates:		''	1 195 Z	2 40 3b	еспу.			Specify:	Whit	e		
	/Cno.	15. Decede			1	16		nt's Usual (kına	16b.	Kind of Bus	iness/In	dustry		
	Elementary/Seco			e completed) College ((1-4or 5+)		life. DO	O NOT use	retired)	g most of wor		Inv	restme	ent I	Firm		
				30090 (4	C	lerk										
17.	. Father's Name	(First, Middle	e, Last)		_				18.	Mother's Nan	ne (First, Midd	lle, Maide	an Sumame)			
	Thomas M	fayo Ho	ffmar	a, Sr.					Ba	arbara	Jane Jo	hnsor	a.				
	9a. Informant's N			•		19	9b. Mailing	Address /S			ral Route Nun			State. Zir.	Code)		
	Barbara 3				ar.					Avenue							
0-	a. Method of Dis		/IIII	11/140 0116		20b. Place				Avenue	Date		Location - C		, MD 2122		
200	1 Burial 2		n 3 □ F	Removal from		cemet	tery, crema	tory or othe	er place)	l	Apr 7	200.	Location	only on re	Jan, State		
	4 Donation	5 Other	(Specify)			Chesa	peake	e Crem	natory		2006	Bel	tsvill	Le, M	Maryland		
21	1. Signature of Fu	uneral Servic	e Licens	99													
1	7	h. h.	o Ri	The	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives												
23	3a. Part1. Enter t	the disease	× ~	/ V V V V V V V V V V		MA											
		une disease,	23a, Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,														
shock, or heart failure. List only one cause on each line.													LMOLE,	Mar	Approximate Interval Between Onset and Death		
Immediate Cause (Final disease or condition resulting in death) METASTATIC COLORECTAL CANCER Due to (or as a consequence of):													IMOTE,	Mar	Approximate Interval Between		
dia	nmediate Cause isease or condition	art failure. Li: (Final on	or compl st only or	ne cause on	each line. 'ASTAT	ric co	o not enter	the mode o	of dying, su	ch as cardiad			imore,	Mar	Approximate Interval Between		
di: re	nmediate Cause isease or condition issulting in death)	art failure. Li	st only of	MET Due to	each line. 'ASTAT (or as a co	FIC CO	DLORE(the mode o	of dying, su	ch as cardiad			niiore,	Mar	Approximate Interval Between		
di: re	nmediate Cause isease or condition issulting in death)	art failure. Li	st only of	MET Due to	each line. 'ASTAT (or as a co	ric co	DLORE(the mode o	of dying, su	ch as cardiad			IMOTE,	Mar	Approximate Interval Between		
di: re	nmediate Cause isease or condition sulting in death) equentially list color, any, leading to incuse. Enter Unda ause (Disease or at initiated events	art failure. Li	st only of	MET Due to	each line. 'ASTAT (or as a co	FIC CO	DLORE(the mode o	of dying, su	ch as cardiad			LMOTE,	Mar	Approximate Interval Between		
Se ca ca tha	nmediate Cause isease or conditionsulting in death) equentially list coloring any, leading to include. Enter Undea ause (Disease or ause (Disease or ause)	art failure. Li	st only of	MET Due to Due to	each line. ASTAT Of (or as a co	FIC CO	DLORE(e of):	the mode o	of dying, su	ch as cardiad			LMOLE,	Mar	Approximate Interval Between		
Se ca ca tha	nmediate Cause isease or condition sulting in death) equentially list color, any, leading to incuse. Enter Unda ause (Disease or at initiated events	art failure. Li	st only of	MET Due to Due to	each line. ASTAT Of (or as a co	TIC CC	DLORE(e of):	the mode o	of dying, su	ch as cardiad				Mar	Approximate Interval Between		
di: re	nmediate Cause isease or condition sulting in death) equentially list color, any, leading to incuse. Enter Unda ause (Disease or at initiated events	art failure. Li	st only of	MET Due to Due to	each line. ASTAT Of (or as a co	TIC CC	DLORE(e of):	the mode o	of dying, su	ch as cardiad				Mar	Approximate Interval Between		
Se ca ca tha	nmediate Cause isease or conditions used in death) equentially list contains, the camp, leading to include. Enter Under ause (Disease or at initiated event isulting in death)	art failure. Li (Final on onditions, mmediate erlying r injury s Last	st only of	MET Due to Due to	each line. ASTAT (or as a control of contr	FIC CO	DLORE(e of):	the mode o	of dying, su	ch as cardiad					Approximate Interval Between Onset and Death		
See ca ca charren	nmediate Cause isease or condition southing in death) equentially list or any, leading to in ause. Enter United ause (Disease or at initiated event southing in death) FEEMALE: 3b. Was deceder in the past 12	art failure. Li (Final on onditions, mmediate ertying r injury s Last	st only of	ne cause on . MET Due to Due to Due to 23c. If yes, ou 1 ☐ Live	each line. ASTAT (or as a control of the control	ensequence	DLORE(e of): e of): th 3 □E	CTAL (of dying, su	ch as cardiad			23d. Date	of delive	Approximate Interval Between Onset and Death		
Se di a Ca tha res	nmediate Cause isease or conditions under the southing in death) equentially list control and the south is th	art failure. Li (Final on on onditions, mmediate erlying r injury s Last the pregnant on months?	st only of	ne cause on . MET Due to Due to Due to 23c. If yes, ou 1 ☐ Live	each line. CASTAT Of or as a control of the contr	FIC CO	DLORE(e of): e of): th 3 □E	CTAL (of dying, su	ch as cardiad			23d. Date	of delive	Approximate Interval Between Onset and Death		
disre	nmediate Cause isease or condition southing in death) equentially list or any, leading to include ause (Disease or at initiated event southing in death) FEMALE: 3b. Was deceder in the past 12 1 Yes 2 9 Unknown	art failure. Li (Final on onditions, mmediate ertying r injury s Last the pregnant months?	st only of	Due to Due to Due to Due to Due to	each line. ASTAT (or as a control of a con	FIC CO	DLORE(e of): e of): th 3 DE 5 D C	CTAL (CTAL)	CANCE	R	or respiratory	arrest,	23d. Date Mon	of delive	Approximate Interval Between Onset and Death onset and Death		
Se ca ca tha res	nmediate Cause isease or conditionsulting in death) equentially list contains any, leading to include ause (Disease or at initiated event issulting in death) FEMALE: 3b. Was deceder in the past 12 1 □ Yes 2	art failure. Li (Final on onditions, mmediate ertying r injury s Last the pregnant months?	st only of	Due to Due to Due to Due to Due to	each line. ASTAT (or as a control of a con	FIC CO	DLORE(e of): e of): th 3 DE 5 D C	CTAL (CTAL)	CANCE	R	or respiratory	d tobacco	23d. Date Mon	of delive	Approximate Interval Between Onset and Death Onset and Death Park Park Park Park Park Park Park Park		
Se ca ca tha res	nmediate Cause isease or condition southing in death) equentially list or any, leading to include ause (Disease or at initiated event southing in death) FEMALE: 3b. Was deceder in the past 12 1 Yes 2 9 Unknown	art failure. Li (Final on onditions, mmediate ertying r injury s Last the pregnant months?	st only of	Due to Due to Due to Due to Due to	each line. ASTAT (or as a control of a con	FIC CO	DLORE(e of): e of): th 3 DE 5 D C	CTAL (CTAL)	CANCE	R	or respiratory	d tobacco	23d. Date Mon	of delive	Approximate Interval Between Onset and Death Onset and Death Park Park Park Park Park Park Park Park		
Se ca ca tha res	nmediate Cause isease or condition southing in death) equentially list or any, leading to include ause (Disease or at initiated event southing in death) FEMALE: 3b. Was deceder in the past 12 1 Yes 2 9 Unknown	art failure. Li (Final on onditions, mmediate ertying r injury s Last the pregnant months?	st only of	Due to Due to Due to Due to Due to	each line. ASTAT (or as a control of a con	FIC CO	DLORE(e of): e of): th 3 DE 5 D C	CTAL (CTAL)	CANCE	R	23e. Di	d tobacco	23d. Date Monto	of deliver	Approximate Interval Between Onset and Death Onset and Death Park The Cause of death? Day Year Dably 4 Munknot oppy findings availal		
dicree	nmediate Cause isease or condition southing in death) equentially list or any, leading to include ause (Disease or at initiated event southing in death) FEMALE: 3b. Was deceder in the past 12 1 Yes 2 9 Unknown	art failure. Li (Final on onditions, mmediate ertying r injury s Last the pregnant months?	st only of	Due to Due to Due to Due to Due to	each line. ASTAT (or as a control of a con	FIC CO	DLORE(e of): e of): th 3 DE 5 D C	CTAL (CTAL)	CANCE	R	23e. Di 1[24a. W	d tobaccc Yes as an topsy frormed?	23d. Date Mon	of delive	Approximate Interval Between Onset and Death Onset and Death		
dicree	nmediate Cause isease or condition southing in death) equentially list or any, leading to in ause. Enter Undeause (Disease or at initiated event issulting in death) FEMALE: 3b. Was deceder in the past 12 1	art failure. Li (Final on on onditions, mmediate erlying r injury s Last the pregnant c months?	ations con	Due to Due to Due to Due to Due to	each line. ASTAT (or as a control of a con	FIC CO	DLORE(e of): e of): th 3 DE 5 D C	CTAL (CTAL)	inancy se given in	Part I.	23e. Di 1[24a. W au pe 1 □ Yes	d tobaccc Yes as an topsy rformed?	23d. Date Mon	of delive	Approximate Interval Between Onset and Death Onset and Death Park The Cause of death? Day Year Dably 4 Munknot oppy findings availal		
diagram diagra	nmediate Cause isease or condition southing in death) equentially list or any, leading to in ause. Enter Understanding to in ause (Disease or at initiated event). FEMALE: 3b. Was deceder in the past 12 1	art failure. Li (Final on on onditions, mmediate ertying riving s Last tr pregnant months? Months No on officant conditions officant conditions officant conditions officant conditions officant conditions officant conditions officant conditions officant conditions officant conditions	ations col	a. MET Due to b. Due to c. Due to d	each line. **ASTAT **(or as a control of the cont	ensequence consequence consequ	DLORE(e of): e of): th 3 DE 5 D C	CTAL (CTAL)	inancy in in in in in in in in in in in in in	Part I.	23e. Di 1[24a. Wi au pe 1 □ Yes	d tobacco	23d. Date Monto use contril 2 □ No 24b. W pr de	of deliver th	Approximate Interval Between Onset and Death Onset and Death Park Park Park Park Park Park Park Park		
diagram diagra	equentially list or any, leading to ir ause. Enter Unduse, Enter Unduse, Enter Unduse, (Disease or at initiated event is sulting in death) FEMALE: 3b. Was deceder in the past 12 1	art failure. Li (Final on on onditions, mmediate ertying i rinjury s Last tr pregnant months? Mo on on onditions, months? Mo on on on onditions on on on on on on on on on on on on on	ations col	a. MET Due to b. Due to c. Due to d	each line. CASTAT (or as a control of cont	ensequence consequence consequ	DLORE(e of): e of): th 3 E 5 0 g in the unc	CTAL (CTAL (inancy see given in	Part I.	23e. Di 1[24a. Wa pe 1 □ Yes th Check onlone 5 □ Re	d tobacco	23d. Date Monio	bute to the bute to the bute to the bute to the bute to the bute to the bute to the bute to consider the bute to consider the bute the bute to the but	Approximate Interval Between Onset and Death Onset and Death		
diagram diagra	equentially list coany, leading to lisease or condition in death) equentially list coany, leading to lisuse. Enter United auss (Disease or at initiated event; sulting in death) FEMALE: 3b. Was deceder in the past 12 1	art failure. Li (Final on on onditions, mmediate erlying r injury s Last the pregnant c months? No on ifficant condi	ations con	A. MET Due to b. Due to c. Due to d. Preg 9 Unkr https://district.org	each line. CASTAT (or as a control of cont	consequence consequence consequence consequence consequence pregnancy Petal death not resulting	DLORE(e of): e of): th 3 E 5 0	CTAL (CTAL (inancy in in in in in in in in in in in in in	Part I.	23e. Di 1[24a. Wi au pe 1 □ Yes	d tobacco	23d. Date Monio	bute to the bute to the bute to the bute to the bute to the bute to the bute to the bute to consider the bute to consider the bute the bute to the but	Approximate Interval Between Onset and Death Onset and Death		
General distribution of the control	equentially list coary, leading to ruse. Enter Undause (Disease or at initiated event in the past 12 1 Yes 2 9 Unknown art II. Other significant of the past 12 1 Yes 2 1 Yes 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	art failure. Li (Final on on onditions, minediate errlying r injury s Last the pregnant 2 months? No n fificant condit rred to medic (No th 5 Penc inves	tions con	A. MET Due to b. Due to c. Due to d. Preg 9 Unkr https://district.org	each line. CASTAT Or as a control of the control	consequence consequence consequence consequence consequence pregnancy Petal death not resulting	DLORE(e of): e of): th 3 E 5 (g in the unc	CTAL (CTAL (inancy inancy se given in 26. Other: 1. Injury at	Part I. Place of Dea	23e. Di 1[24a. Wa pe 1 □ Yes th Check onlone 5 □ Re	d tobacco	23d. Date Monio	bute to the bute to the bute to the bute to the bute to the bute to the bute to the bute to consider the bute to consider the bute the bute to the but	Approximate Interval Between Onset and Death Onset and Death Park Park Park Park Park Park Park Park		
diagram diagra	mediate Cause isease or condition southing in death) equentially list or any, leading to in use. Enter Unidause (Disease or at initiated events sulting in death) FEMALE: 3b. Was deceder in the past 12 1 Yes 2 9 Unknown and II. Other significant in the past 12 1 Yes 2 9 Unknown and II. Other significant in the past 12 1 Yes 2	art failure. Li (Final on onditions, mmediate erlying rinjury s Last At pregnant c months? No fificant condi	tions con	Accepted in the control of the contr	each line. **ASTAT* **(or as a control of the con	pregnancy pregnancy presulting 2 DER/C and At home,	DLORE(e of): e of): for one of the uncomparison of the uncompar	Ectopic preg Other (spec	inancy inancy se given in 26. Other: Injury at Work? 1 □ Yes	Part I. Place of Dea	23e. Di 1[24a. Way pe 1	d tobacco	23d. Date Monion of Use contril 2 No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	of deliver the bute to the bute to the state of the bute to the state of the bute to the b	Approximate Interval Between Onset and Death Onset and Death		
dicre	equentially list coary, leading to ruse. Enter Undause (Disease or at initiated event in the past 12 1 Yes 2 9 Unknown art II. Other significant of the past 12 1 Yes 2 1 Yes 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	art failure. Li (Final on onditions, mmediate erlying rinjury s Last At pregnant c months? No fificant condi	ations conditions cond	Accepted in the control of the contr	each line. CASTAT Or as a control of the control	pregnancy pregnancy presulting 2 DER/C and At home,	DLORE(e of): e of): for one of the uncomparison of the uncompar	Ectopic preg Other (spec	inancy inancy se given in 26. Other: Injury at Work? 1 □ Yes	Part I. Place of Dea	23e. Di 1[24a. Way pe 1	d tobaccc Yes as an topsy formed? 2 X n y one asidence se how inj	23d. Date Monion of Use contril 2 No 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	of deliver the bute to the bute to the state of the bute to the state of the bute to the b	eny Day Year the cause of death? pably 4 Nunknot opsy findings availal impletion of cause of the		
dicree	equentially list coarry, leading to ruse. Enter Undause (Disease or at initiated event sulting in death) FEMALE: 3b. Was deceder in the past 12 1 Yes 2 9 Unknown art II. Other significant of the past 12 1 Yes 2 1	art failure. Li (Final on on onditions, mmediate erlying r injury s Last ht pregnant 2 months? W No ifficant condi (No th 5 Penc inves 6 Coul detei	tions col	A Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. PASTAT Or as a control of a saccontrol of a sacco	pregnancy pregnancy Fetal death not resulting 2 ER/C (ear) 28b - At home, (Specify)	o not enter DLORE(e of): e of): th 3 E 5 0 Quitpatient Time of Injury farm, street	Ectopic preg Other (spec derlying cau 3 □ DOA 28c M et, factory, c	inancy inancy se given in 26. Other: Injury at Work? I Yes	Part I. Place of Dea	23e. Di 1[24a. W au pe 1	d tobacco	23d. Date Month of Use contril 2 No 3 No 1 No 1 No 1 No 1 No 1 No 1 No 1	of deliver the bute to the state of the stat	Paperoximate Interval Between Onset and Death Onset and Death Paperoximate Interval Between Onset and Death Paperoximate Agriculture of Death Paperoximate Interval Paperoximate		
distress See fire can care care care care care care care care	equentially list coany, leading to read the south of the	art failure. Li (Final on on onditions, mmediate eritying rinjury s Last Ant pregnant months? No on ifficant condi No th S pend inves 6 Coult detei 12 Certify 2 Medica	tions col	A Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. CASTAT Or as a control of the control	pregnancy pregnancy Fetal death not resulting 2 ER/C (ear) 28b - At home, (Specify)	o not enter DLORE(e of): e of): th 3 E 5 0 Quitpatient Time of Injury farm, street	Ectopic pregother (specifi	inancy se given in 26. Other: 1 North at North Action of the time, do not not not not not not not not not no	Part I. Place of Dea Nursing H 2 \(\sum \) No	23e. Di 1[24a. W au pe 1	d tobacco	23d. Date Moni 2 In No 24b. W pr de No 1 In 6 X Othe jury occurre and Number are) (s) and man and place, and	of deliver the bute to the bute to the bute to the bute to the constant? Yes r (Specified of the constant)	Approximate Interval Between Onset and Death Onset and Death Onset and Death D		
distress See fire care care care care care care care ca	equentially list coarry, leading to ruse. Enter Undause (Disease or at initiated event sulting in death) FEMALE: 3b. Was deceder in the past 12 1 Yes 2 9 Unknown art II. Other significant of the past 12 1 Yes 2 1	art failure. Li (Final on on onditions, mmediate eritying rinjury s Last Ant pregnant months? No on ifficant condi No th S pend inves 6 Coult detei 12 Certify 2 Medica	tions col	A Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. PASTAT Or as a control of a saccontrol of a sacco	pregnancy pregnancy Fetal death not resulting 2 ER/C (ear) 28b - At home, (Specify)	o not enter DLORE(e of): e of): th 3 E 5 0 Quitpatient Time of Injury farm, street	Ectopic pregother (specifi	inancy inancy se given in 26. Other: Injury at Work? I Yes	Part I. Place of Dea Nursing H 2 \(\sum \) No	23e. Di 1[24a. W au pe 1	d tobacco	23d. Date Monton of Use contril 2 No 3 No 1 No 1 No 1 No 1 No 1 No 1 No 1	of deliver the bute to the bute to the saturation to co-saturation of the saturation	Approximate Interval Between Onset and Death Onset and Death Onset and Death D		
distress See fire care care care care care care care ca	equentially list coany, leading to read the south of the	art failure. Li (Final on on onditions, mmediate eritying rinjury s Last Ant pregnant months? No on ifficant condi No th S pend inves 6 Coult detei 12 Certify 2 Medica	tions col	A Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to Due to	each line. PASTAT Or as a control of a saccontrol of a sacco	pregnancy pregnancy Fetal death not resulting 2 ER/C (ear) 28b - At home, (Specify)	o not enter DLORE(e of): e of): th 3 E 5 0 Quitpatient Time of Injury farm, street	Ectopic pregother (specifi	inancy se given in 26. Other: 1 North at North Action of the time, do not not not not not not not not not no	Part I. Place of Dea Nursing H 2 \(\sum \) No	23e. Di 1[24a. W au pe 1	d tobacco	23d. Date Monton of Use contril 2 No 3 No 1 No 1 No 1 No 1 No 1 No 1 No 1	of deliver the bute to the bute to the bute to the bute to the constant? Yes r (Specified of the constant)	Approximate Interval Between Onset and Death Onset and Death		
dicree dicase di caracteria di	equentially list coany, leading to read the south of the	art failure. Li (Final on on onditions, mmediate ertying in injury s Last the pregnant months? No on on on on on on on on on on on on on	tions contains ding thing the stigation do not be mined thing Physical Examilation	A Due to b. Due to b. Due to co. Due to d. Due	each line. **PASTAT* **(or as a control of the co	pregnancy pregnancy Petal death not resulting 2 DER/C (ear) 28b - At home, (Specify) my knowled (camination a	DLORE o of):	Ectopic preg Other (spec derlying cau 3 DOA A Bet, factory, cocurred at assignation, in	inancy se given in 26. Other: 1 North at North Action of the time, do not not not not not not not not not no	Part I. Place of Dea Nursing H 2 \(\sum \) No	23e. Di 1[24a. W au pe 1	d tobacco	23d. Date Monton of Use contril 2 No 3 No 1 No 1 No 1 No 1 No 1 No 1 No 1	of deliver the bute to the bute to the saturation to co-saturation of the saturation	Approximate Interval Between Onset and Death Onset and Death		
dicree dicase di caracteria di	equentially list coarry, leading to ruse. Enter Unda ause (Disease or at initiated eventially list coarry, leading to ruse. Enter Unda ause (Disease or at initiated eventially list of the past 12 1 Yes 2 9 Unknown art II. Other significant of the past 12 1 Yes 2 9 Unknown art II. Other significant of the examiner? 1 Yes 2 2 3 Yes august 12 Accident 3 Suicide 4 Homicide 9a. Certifier (Check only one)	art failure. Li (Final on on onditions, mmediate eritying rinjury s Last the pregnant months? No on ifficant condi rred to medic No th Certify 2 Medica dritte of period less of person	tions col	A. MET Due to b. Due to c. Due to d	each line. CASTAT Or as a control of the control	pregnancy pregnancy Petal death not resulting 2 DER/C (ear) 28b - At home, (Specify) my knowled (camination a	Dutpatient Dutpatient Time of Injury farm, street a) (Type, P.	CTAL CECTOPIC preg Other (spec Detrying cau Betyling cau Betyling cau Betyling cau Betyling cau Cecurred at stigation, in coccurred at stigation, irrint)	inancy inancy se given in 26. Other: 1 North at Mork at Mor	Part I. Place of Dea Nursing H 2 \(\text{No} \) ate and place n, death occumber	23e. Di 1[24a. W au pe 1	d tobacco Yes as an topsy rformed? s 2X N y one) asidence be how injusted to the cause of t	23d. Date Monto use contril 2 No 3 No 1 1 No 1 No 1 No 1 No 1 No 1 No	of deliver the bute to the bute to the saturation to co-saturation of the saturation	Approximate Interval Between Onset and Death Onset and Death		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 5, **Physician** ^{Day} 2006 Year Mary Ruth Hopkins 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dulaney Manor Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**X** F Months Yrs. 212-28-6641 Director Nov. 1928 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Madical Exercine roust be nutified at Director 1 ☐ Yes 2 No Baltimore Md. Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 14 Nightinga<u>le Way</u> Apt. A-2 21093 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or itams 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. important: if item 27 is marked other then "na any injury or other traumatic event, the Madic 2006. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Farming Machinery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louis Vernon Coen Mary Jemina McComas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie A. Florian/Daughter 600 Park Lane Towson, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Presbyterian 4/7/06 Jarrettsville, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** emen-/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical use as I 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform certificate 1 Yes Division of Vital 2 40 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔄 No 2 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: t Danural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident t Director: d in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HO054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 20 E. Timonium rd. suite #209 Timonium MD 21093 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Sarah Kathryn Hess 29, 6:45 P M March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Hart Heritage Home Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Director Yrs. 159-24-8041 88 1918 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits I7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 104 Dallas Court 21085 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 and 2 should be filed within 72 hours after v Health and Mental Hygiene. 8m 27 is marked other than "natural; or itar 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No 3√2 Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Procurement Specialist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sam (nmn) Yost (unk) (unk) Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trau once. Richard T. McHenry / Son 104 Dallas Court, Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 Tother (Specify Entombment Woodlawn Mem. Cem. 4-1-06 Baltimore, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, Marle T. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the diseate, of shock, or heart failure. nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hend Consestin **Physician** disease or condition resulting in death) 413 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Triu FACILLU 1 Yes 2 No 3 Probably 4 No Nknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed2 2/2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: funeral director psisted Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) CARR 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MARCH 31,2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL RD Bel AIR, UD 21014 SPANUS ALFRED 31. Date filed (Month, Day, Year) 32. Registrar's Signature Alexan & Sperk Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Physician /Medical Facility Name (If not i stitution, give stre Examiner 7. Age (In yrs last birthday) Social Security Number **Funeral** Days Hours 1 □ M 2 K F 219-28-602 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State Town or Location 10d. Inside City Limits 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? or Iteme 23a or one 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) eacher permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other
any Injury or other traum-**: 17 Father's Name (First, Middle er's Name (First, Middl Be 19b. Mailing Address (Street and No Baltimore, Method of Disposition Burial 2 Cremation 3 Pemoval from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service License 23a. Part1. Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** >E /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner Due to (or as a consequence of). The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 the attending physicien IE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ector, page 2 should be QUADREPARESIS SELEVDAN 3 Probably 4 Unknown 1 ☐ Yes Medical Certification: To Be Completed peen DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed RIGHT KEDNEY this certificate 1 Yes 2₽No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 70 Other: 4 Nursing Home 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation death 2 Accident the within 24 hours after death To the Funaral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

To the h

State Registrar

CRUANDE 13. 31. Date filed (Month, Day, Year)

29b. Signature and title of certified



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7501 Grenty Rd. BALTIMORE, Ref. 21207

29c. License number

18502

29d. Date signed (Month, Day, Year)

Amend itm#10e,20a-C, perfit in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day 06 4 5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beld Jose 6 to spice Md If Under 1 Year If Under 24 Hrs.
Months Davs House Bald. hur 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) Birthplace (State or Foreign
 A Bountry) **Funeral** 10 M 20 F Year) 212-48-8666 Director Yrs. 5 ano Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at md 1 Yes 2 No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2210 E. Lanvale Street or iteme 23a u.S. filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other then " Elementary/Secondary (0-12) Coltage (1-4or 5+) mprovemen 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be 1995 VDr man 19a. Informant's Name/Relationship (Type, Pin) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) inda Ho.Ma.2/2/ 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 5 permit. Page Department of Important: If eny injury or once. 4/20/2006 Greenmount Crematory 4 ☐ Donation 5 ☐ Other (Specify) Joseph L. Russ 2272 W. North 21 Signstage of Funeral Service Licenses Ave Juneral Home Enter the dy ease, or complications that bused to , or heart shure. List only one cause on each line. d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immedime Cause (Final disease or condition resulting in death) Physician pha 0 /Medical Due to (or as a consequence of): Examiner chro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine he Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 DEetal death 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for a in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 Probably 1 Yes 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 25 No 1 Yes 1 Tes To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Flespic 2 1 ☐ Yes 2 ☐ No 2 FR/Outnatient 3 DOA 27. Manner of Death 28c. Injury at Work? Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signes (Month, Dav. Year) D7688C 3 30. Name and address person completed cause of death (Item 23a) (Type, Print) Pluce 360 Army 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1- State of Maryland / Department of Health and Mental Hygi Certificate of Death	ene 006 10885
	Physicia /Medic	ın	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, April	Day, Year 9.20 M
	Examin Funeral	er	4a. Facility Name (If not institution, give street and number). 4b. City, Town, or Location of Death 4c. City, Town, or Location of Death 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	4c. County of Death Batternau 9. Birtholace (State or Foreign
	Director		218-28-8383 TM 2DF 72 Yrs. Months Days Hours Min. Aug. 27 Usual Residence of Decedent	Year) 9. Birthplace (State or Foreign Country) Maryland
Å,	the Maryland 28a-f ehow	ctor	10a. State 10b. County N/A 10c. City, Town or Location	10d. Inside City Limits 110 Yes 2 □ No
30	deeth with the me 23e or 28e r.must be not	ral Dire	10e. Street and Number 1351 Ward St. 21230	og. Citizen of What Country?
980	or Ite	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Noivorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Noivorced 12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
) 21215-0036	e filed within 72 hours il Hygiene. other then "netural", vent, Le Mudical Exi	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	6b. Kind of Business/Industry Warner Erry Hange
2006	s 1 end 2 should be filed within if Health and Mental Hygiene. Item 27 le marked other than other traumatic event, Le M	To Be Co	17. Fathers Name (First, Middle, Last) 18. Mothers Name (First, Middle, M. Kichard Tackson SR. Puccey	laiden Sumame) DOVAN
	s 1 end 2 shoul			acto, md. 21216
LA Y	Page nent o ant: If ury or		1 Seurial 2 Cremation 3 Removal from State Cemetery, crematory or other place) 4 Departion 5 Other (Specify) The complete of the complete of	and une md.
a a a	Permit Depart Import Import Information Import Information Import Information		22. Name and Address of Facility 22. Name and Address of Facility 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinations or height a disease or condition. 23. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinations or condition. 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 29. Name and Address of Facility 21. Supplied to the district of the death of the	
λ	/Medical Examiner	Examiner	resulting in death) Due to (or as a consequence of): Sequentially list conditions, large	
8760	ate be nysicie he bur	Cal	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.	
P.O. Box 6	It the death certifica by the ettending ph tached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 5 □ Other (specity) □ Unknown	23d. Date of delivery Month Day Year
		þ		acco use contribute to the cause of death?
Vital Becords	The law ete has b page 2 sl	Completed	24a. Was an autopsy perform 1 1 Yes 2	prior to completion of cause of death?
~ To	ding Physician: h. After this certific funeral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 X No	nce 6 Other (Specify) Hospice
Blusion	Attending Physician: r death. sctor: After this certific by the funeral director,	Certification: To	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office 28d. Describe how Work? 28d. Describe how Work? 1 Yes 2 No 28d. Describe how Work? 28d. Describe how Work? 28d. Describe how Work? 28d. Describe how Work? 28d. Describe how Work? 28d. Describe how Work? 28d. Describe how Work? 28d. Describe how Work? 28d. Describe how Work? 28d. Describe how Work? 28d. Describe how Work?	w injury occurred # eet and Number or Rural Route Number.
S S	To the Hospital or Atlandi within 24 hours etter death. To the Funeral Director: A completely filled in by the fu	al Certif	building, etc. (Specify) City or Town, 29a. Certifiler 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ca	State)
	thin 24 h	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, da and manner stated.	ite and place, and due to the cause(s)
	F ₹ 5 8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1) A R. (ey 6 BMC 670 (K. Charles St. Balts. M.	
_	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. R. Ley G. B. M. 670 (K. Charles St. Balts. M	1d 20208
	Sta Registra		31. Date filed (Month, Day, Year) 32. Postrar's Signature APR 0 7 2006	

State of Maryland / Department of Health and Mental Hygiene

			514.6 57 181	arylana / E	Certificate of		R	eg. No.	10880
190	Physicia	n	1. Decedent's Name (First, Middle, Last)			1	2. Date of Dea	th	3. Time of Death
	/Medica		Roland Virgil Jackson				April	1, Day 2006 ear	
	Examine	r	4a Facility Name (If not institution, give street and number) Manor Care Roland P			4b. City, Town, or Lo Baltim		4c. County of Dea	ath / A
	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last bir	thday) If Under 1 Year	If Under 24 Hrs.			rthplace (State or Foreign country)
	Director			82	Yrs. Months Days	Hours Min.	Oct 1	2,1923	MD
	land land	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow					10d. Inside City Limits
	Mary a-fah	ğ	MD N/A		Baltimore	9			1 🖾 Yes 2 🗆 No
	th with the 23a or 28.	a Direc	10e. Street and Number 5430 Park Heights Apt	# 208	10f. Zip Code	21215	1	0g. Citizen of What C	country? USA
21215-0020	72 hours efter death with the Maryland natural; or items 23a or 28a-f show iteal Examiner must be notitied at	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 Hres, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: B	ite, etc.
5	"natural",	etec	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of work	ing	16b. Kind of Business	s/Industry
121	within ene.	E E	Elementary/Secondary (0-12) College (1-4or	5+) P	<i>life. DO NOT use retire</i> acker	id)		Seal Test	t Dairv
	other	စ္က	12th 17. Father's Name (First, Middle, Last)			18. Mother's Nam			o -all
ylar	ould be f Mental I Markad of Maric ava	0	Norman Jackson			Bessi	е		
Maryland	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumetic avant, the Medical once.	1	19a. Informant's Name/Relationship (Type, Print) Jenny Patterson / Daug	19b	. Mailing Address (Street	and Number or Rur	al Route Number	, City or Town, State,	Zip Code)
	1 and Healt em 27	-	20a. Method of Disposition		f Disposition (Name of ry, crematory or other pla			IOTE MD 2 20c. Location - City o	
Baltimore,	Pages ent of nt: If it ry or o		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Spenial Combine)				4/5/06		
alti	permit. I Departm Importar any inju		21. Signature of Fineral Service Licensee	L DIU.	id Ridge C 22. Name and Addre			Pikesvill	le MD ineral Home
8	89 = 8	1	They yours		5240 Rei	stersto	wn Rd I	Baltimore	MD 21215
	8/3		23a. Part. Enter he disease, or complications that caused shock, or heart failure. List only one cause on each li	I the death. Do no.	not enter the mode of dyin	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between
1	Physician /Medical		Immediate Cause (Final	+ t 1	Pan	eta est a	Ca-	0.0	Onset and Death
	Examiner		disease or condition resulting in death)	e stat	consequence of):	Rese Dise	- m	CES	1
	י אַ		Ga	store	Comcer	Rese	etin		1
V	ertificete be executed ing physician end e as the bunal-transit	edical Examiner	D		consequence of):	h *			
68760,	sician buna	<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	vonen	Bothy	Dice	are		
687	tificete ig phy as the	Medi	resulting in death) Last	Due to (or as a c	consequence of):	10/0-	P021-	Ed.	I I
Вох	th cert tendin or use	any	d	non	- Curron	8 CV VW	FU31-	10 mg	
	the at thed fo	rnysician	Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause given	ven in Part I.	23b. Did to	bacco usa contribut	te to the cause of death?
P.O.	that the ded by detection	-	mamie				1 □ Y	es 2□No 3□F	Probably 4 Tunknown
Records,	The law requires that the death certificete be ate has been signed by the attending physicial page 2 should be deteched for use as the bur	completed by	Degenratine J	ont	Difeau		24a. Was a perform		Were autopsy findings available prior to completion of cause of death?
æ	The law te hes vage 2	E					10%	s 2EN	1 ☐ Yes 2 ☐ No
of Vital	certificate		25. Was case referred to medical examiner?			26. Place of Deat	h (Check only on	10)	
of V	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie		itpatient 3L DOA			ence 6 □Other (Sp	ecify)
ono	ding F. h. After funer		27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Da	Y Year) 28b. I	rime of 28c. Injui njury Wo	ryat rk? Yes 2 □ No	28d. Describe h	ow injury occurred	
Division	tal or Attending Physician: s effer death. al Director: After this certific led in by the funeral director,	e I II Ca	3 ☐ Suicide 6 ☐ Could not be	ury - At home, fa c. (Specify)	rm, street, factory, office		28f. Location (Si City or Town	reet and Number or F n, State)	Rural Route Number,
_	To the Hospital or Attending Physicien: The I within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner steep and manner steep.	examination and	, death occurred at the tir d/or investigation, in my o	me, date and place, opinion, death occur	and due to the cared at the time, d	ause(s) and manner a ate and place, and du	as stated. le to the cause(s)
	To th To th comp	2	29b. Signature and title of certifier		29c. Licens		2	9d. Date signed (Mon	nth, Day, Year)
) Sam	~ n		31469		41110) 6
	2		30. Name and address of person who completed cause of d SHDA(13 A. HAP Ham)	eath (Item 23a) ((Type, Print)	or hanto	302 13	PALTIMAN	E MD 2120
	State			ar's Signature	1.07(11)107	1 ornu	700 1		C VID CICO

DHMH 16 Rev 6/95

Registrar

			For State	State of Marylan	•			LUUD	10887
			1. Decedent's Name (First, Middle, Last)	8 Per FH 8854	4/21/06°	in Or Death	2. Date of Death	. No.	3. Time of Death
	Physicia /Medic		Charlotte	Johns	on		April	Day Year	12:05 AM
A. S. C.	Examin		4a. Facility Name (If not institution, give s			, Town, or Location of Dea	th	4c. County of Death	
			5. Social Security Number 6. Sex	1 HOSDITO	last birthday) If Und	Salti MOV (9. Birthr	place (State or Foreign
	Funeral Director			IM 20 F 83	Yrs. Months	Days Hours Min	8. Date of Bigh Month, 20, Y	923 Ma	ryland
	and *		Usual Residence of Decedent 10a. State 10b. County ,	10c. Cit	y, Town or Location		,	1	10d. Inside City Limits
	Maryt	to	Moruland N/A	F	Baltimo	ice.			1 XYes 2 No
	or 28a	Oirec	10e. Street and Number	+ 01		ip Code	10g	. Citizen of What Cour	ntry?
	death with the Maryland ms 23a or 28a-f show r numbe notified at	Funeral Director	4502 Harco	12. Was Decedent Ever in U.	S 13 Was Dec	2/2/4 edent of Hispanic Origin? (Specify Yes or No-	14. Race - Americ	can Indian.
9	after d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Yes 2 No If Yes, Give	If Yes, sp 1 ☐ Yes	ecify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White,	
21215-0036	within 72 hours after ene. then *natural; or ite he Medical Examilia	d by	3 Widowed 4 □ Divorced	Year or Dates:			16	Specify: Blooms. Since Specify: Blooms Specify	ack
7	in 72 l n *nat fedica	plete	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	rork done during most of we	orking	o. King of business/in	dustry
	fited with Hygiene other the	Completed	Elementary/Secondary (0-12)		Nu	se		Hospi	tal
Maryland	ntal Hy od oth	Be	17. Father's Name (First, Middle, Last)	ttan		18. Mother's Na	ime (First, Middle, Ma	iden Sumame) 	16.1
ž Ž	should and Men is marke	ဥ	19a. Informant's Name/Relationship (Ty	pa, Print) Janya hter	19b. Mailing Addre	ss (Street and Number or F	Rural Roule Number, C	ity or Town, State, Zig	C db)
_	and 2 salth a n 27 is		Ms. Hannah	Wildy	4502	Harcou	rt Rd. 1	Balto.M	d. 21214
lore	Pages 1 and 2 should be filed within 72 hours after death with the Marylan tent of Health and Mental Hygiene. Int: if item 27 is marked other than "natural", or items 23a or 28a-1 show int: if item 27 is marked other than "natural", or items 23a or 28a-1 show int of other traumatic event, the Madical Examitme outst be malified a		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R	emoval from State	Place of Disposition (Nemetery, crematory of	ame of other place)	1/2001/	c. Location - City or To	MA-11- M
Baltimore,	Department Department mportant: any injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		USTISOT 22. Name	and Address of Facility	1/2006	wings	MILK, Ma.
B	permit. Departm Importa any inju		· Joseph	L. Kus	1 Joseph 2222	W. North AV	ineral Ho	Ma:21216	
			23a. Part / Enter the disease, or complished, or heart failure. List only or	cations that caused the deat ne cause on each line.	h. Do not enter the ma	ode of dying, such as cardia	ac or respiratory arres	ι,	Approximate Interval Between Onset and Death
Ž.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	ric Ade	no Carcin	ma		4 months
	Examiner		Conservation to that are stated	MR.ST	4 UTI			2	anchy
V	be sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq		2.42		٠	· eali
9	execut n and ial-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	with quence of):	KVA			, weeks
8760,	cate be executed oblysicien and the burial-transit		C.	J					
9	death certificate e attending phys d for use as the	Physician/Medical	IF FEMALE:	3c. If yes, outcome of pregna	ancy			23d. Date of delive	Priv
. Box	death e atten id for u	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	ıl death 3 □Ectopic			Month	Day Year
P.O.	that the de ned by the a detached	Phys	9 Unknown Part II. Other significant conditions con	9 Unknown	ulting is the westerbine	anuna muan in Port I	23e Did toba	cco use contribute to t	the cause of death?
	uires tha signed Id be de	d by	Part II. Other significant conditions con	ithouling to death but not les	aiting in the underlying	cause given in Fait i.		2 □ No 3 □ Prot	. /
COL	faw requires as been sign 2 should be	Completed					24a. Was an	24b. Were auto	opsy findings available ompletion of cause of
- Re	The ate h page	Com					autopsy performe 1 Yes 2	death? No 1 ☐ Yes	
Vita	Physician: 1 this certifical ral director, p	Be	25. Was case referred to medical examiner?	tospital:		Other	eath (Check only one)		
Division of Vital Records,		n: To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	ce 6 Other (Special injury occurred	<u>ny)</u>
sior	Attending I ir death. ector: After by the funer	catio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		М	1 ☐ Yes 2 ☐ No	001		
ΟĬ	aftar d aftar d Direct	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact fy)	ory, office	City or Town,	et and Number or Run State)	al Houle Number,
	To the Hospital or Attendin within 24 hours aftar death. To the Funeral Director: A completely filled in by the fu	ledical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina	owledge, death occurre	ed at the time, date and place	ce, and due to the cau	se(s) and manner as s	stated.
	To the h within 24 To the h complete	Med	29b. Signature and title of certifier	and manner stated.	2	9c. License number	290	d. Date signed (Month,	Day, Year)
	~ > P 0		> 5/2x	Ke Kirs	(= m.)	AT2437	1946	April 1st.	2006
	1		30. Name an drass of person who	mpleted cause of death (Iter	m 23a) (Type, Print)	n Temor	- 11 11-	1100	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	and party	n 1(emor	al story	test 11)	1)
	Regist		APR 6 7 20	16 Bleva A	2. Page				

Edward Jeter 06-02221 NJM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland		ent of Health ar ate of Death		C 0 8 0	10883					
			Registrar 1. Decedent's Name (First, Middle, Last) ,	Ochano	ale of Bealif	Reg.	No.	3. Time of Death					
	ysicia		Edward	Totor			March	31 200						
*	/ledic amin		4a. Facility Name (If not institution, give	street and number)	4b. C	City, Town, or Location of		4c. County of De						
			908 N. Luzerne Av	enue		Baltimore		N/	A					
Fund Direct			5. Social Security Number 6. Se 2/6-90-5396 10 Usual Residence of Decedent	7. Age (In yrs. le	Yrs. If Ur Mont	nder 1 Year If Under 24 ths Days Hours	Hrs. 8. Date of Birth Min. Month, Day, Ye	1977 N	rthplace (State or Foreign buntry)					
aryland •how	T T	ž	10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits 1 (XYes 2 □ No					
th the M or 28a-f	Protifie	Director	Varyland N/	1	altin 10t.	Zip Code	10g.	Citizen of What C						
Jeath wi	math	Funeral C	908 N. LUZ 11. Marital Status	erne Aue 12. Was Decedent Ever in U.S	6. 13. Was D	2/206 ecedent of Hispanic Origin	? (Specify Yes or No-	14. Race - Am	erican Indian.					
Ind 21215-0036 De filed within 72 hours after death with the Maryland hall Hygiene. Indicates then "naturel", or Items 23a or 28s-f show	Examine	ğ	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes,	specify Cuban, Mexican, I s 2 No <i>Specify:</i>	Puérto Rican, etc.)	Specify: R	ite, etc.					
21215-0036 ad within 72 hours all giene.	Aedical	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		Jsual Occupation f work done during most of T use retired)	f working 16t	. Kind of Busines	s/Industry					
d 2121 filed within Hygiene.	nt, the A		Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Lak	DOTET	Name (First, Middle, Mai	Cons	truction					
		To Be	To Be	To Be	Edward J	eter Sr.		la. Wolfred	cretia	Nor	fleet			
= @	ar traumatic		19a. Informant's Name/Relationship (7)	Ter (Brother)	19b. Mailing Add	ress (Street and Number	or Rural Route Number, C	ity or Town, State,	Zip Code)					
O 82=	y or other		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F	00	ace of Disposition (Date 2006 L	Location - City o	r Town, State					
Battir permit. P Depertme Importen	eny injury QDCB.	ł	21. Signature of Funeral Service Livensee 22. Name and Address of Eachity 23. Name and Address of Eachity 24. Donation 5 Other (Specify) 25. Name and Address of Eachity 26. Name and Address of Eachity 27. Name and Address of Eachity											
482		-	23a. Part1/Enter the disease, or comp	ications that caused the death	Do not enter the	W. North	Ave. Bal	to. Md.	212/6 Approximate					
Physic /Medi			shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Cruslos Due to (or as a consequ	wou	rel to h	eacl		Interval Between Onset and Death					
Exami	ner	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence or):										
nd scuted	transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last											
68760, Africate be executed physicien and	he burial	dicai Ey	Todaling in obuilty cast	Due to (or as a consequent.	ence of):									
	22 1		IF FEMALE:	23c. If yes, outcome of pregnan	nev.									
o 🖁 📲	ached for u	d by Physician/M	Ď	۵	2	ysician/	ysician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 ☐Ectopi	ic pregnancy · (specify)		23d. Date of de Month	Day Year
ords, P. requires that	eq					Part II. Other significant conditions co	ntributing to death but not resul	lting in the underlyir	ng cause given in Part I.	23e. Did tobac		to the cause of death? Probably 4 Unknown		
aw aw	9 2 should	Completed					24 a. Was an autopsy	prior to	autopsy findings available completion of cause of					
	, page						performed		s 2 No					
> 🚊 🖁		Be	25. Was case referred to medical examiner?	Hospital:		Other	Death (Check only one)		Coope					
P E E	=	2	1 XYes 2 No 27. Manner of Death	1 Inpatient 2 E	R/Outpatient 3 28b. Time of	DOA 4 Nurs 28c. Injury at Work?	ng Home 5 Residence 28d. Describe how		ecify) Scene					
Division of or Attending Police death. Director: After	the fune	ation	1 Natural 5 Pending investigation	ed Sh	ot									
- 525	od in by	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	t and Number or F tate) 908	Rural Route Number, U.Z.P.N.E. AM.									
To the Hospitel or within 24 hours of To the Funerel D	completely filled in by	edicai (29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my know net. On the basis of examinate and manner stated.	rledge, death occur on and/or investiga	red at the time, date and tion, in my opinion, death	place, and due to the caus occurred at the time, date	e(s) and manner a	s stated					
To the Within	сошр	Me	29b. Signature and title of certifier	Ma		29c. License number	29d.	Date signed (Mor	th, Day, Year)					
			XICH	V///		OCME		April 1,	2006					
	5		30. Name and address of person who co	omplified Juse of death (Item		11 Penn Stre	eet Baltimo	re, Mary	land 21201					
Do	Stat		31. Date filed (Month, Day, Year) ADD 0 7 2006	32. Registrar's Stonatu	IT STATES									

DHMH 17 Rev 1/2001

3:55

			For State Registrar	State of Ma	ryland / De	partme		n and Me	ental Hyg	iene	oie. 6	8	90
	4 1 8 g	11	Decedent's Name (First, Middle, Last)			07111100	ato or boat		2. Date of Deat	eg. No. h		3. Time of	f Death
	Physicia		Louise Pauline	Jacobs					April	2, Day 2006	_Year]	3:44	Рм
	/Medio		4a. Facility Name (If not institution, give s 1433 Burton Ave.	treet and number)		1 .	ity, Town, or Location		•	4c. County of Death Baltimore			
	Funeral		Social Security Number 6. Sex		(In yrs. last birthd				8. Date of Birth (Month, Day,	Vaari	9. Birth	place (State o	or Foreign
,	Director		234-46-7941	M 2XF 90	Yrs	Month i.	ns Days Hour		July 26	, 1915	West	place (State of intry) Virgi	lnia
	nyland how		10a. State 10b. County		10c. City, Town o	r Location				10d. Ins.			ity Limits
	Sa-fs	cto	MD Baltimor	e	Luther	ville				1 Tes 2)			2 X No
	ith th or 28	Director	10e. Street and Number			10f.	Zip Code		1	0g. Citizen of V	Vhat Cou	intry?	
	s 23e		1433 Burton Ave.				21093	01:040				States	
_	itam Itam	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No	verin U.S.	If Yes, s	cedent of Hispanic pecify Cuban, Mexi	origin? (Specican, Puerto R	city Yes or No- lican, etc.)		e - Amen k, White	ican Indian, , etc.	
20	urs af	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	·	1 🗌 Yes	2 No Spec	cify:		Specify	. (U hite	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene d other than "natural", or Itams 23a or 28a-f show event, the Medical Examinar must be notified at	Completed by	15. Decedent's Educ	ation	16a. De	cedent's U	sual Occupation			16b. Kind of Bu	of Business/Industry		
7	thin 7	npie	Elementary/Secondary (0-12)	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)									
7	filed wi Hygien ther th		12 Sales Clerk							Retail		hing S	itore
and E	0 = 0 \$	Be	17. Father's Name (First, Middle, Last)	_1.					(First, Middle, M	Maiden Suman	e)		
Ĕ	2 should be and Mental is marked or raumatic ever	ဥ	George Raymond Peck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri						Alger	C'to a Tama	Ot- 1- 7	- 0- 4-1	
<u>≅</u>	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any Injury or other traumatic er		Donald H. Jacobs/				cton Ave.					p C000)	
စ်	f Hea fram tram other		20a. Method of Disposition		20b. Place of Di			_		20c. Location -		own, State	
Ê	Page ent o nt: If ry or		1 ☐Burial 2 ☐Cremation 3 ☐Re 4 ☐D ∮ ation 5 ☐Other (Specify)	emoval from State	Green H			04/0	5/06	Berryv	ille	- \/Δ	
Baitimore,	mit. partm porta y Inju		21. Signature of Funeral Service License	4			and Address of Fa						Inc.
n	9 9 1 2 3		Ste Ste	phen D. Co	eter		York Roa				210	25/10/	
8	Physician		23 Part Emplified disease, or complied shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Cardia	c Arry	Thmi		as cardiac or	respiratory arre	est,		Approximat Interval Bet Onset and Millute	tween Death
	/Medical Examiner		Tooling in doubly	Due to (or as a	consequence of):	-							
		e	Sequentially list conditions, if any, leading to immediate		consequence of):	2515					-	years	
H	te be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events										
, 60,	e exe sian al urial-t		resulting in death) Last	Due to (or as a	consequence of):								
9/89	w 5 0	dicai	d										_
×	leath certificat attending phy ifor use as the	/Me	IF FEMALE:								22d Data of delivery		
Rox	death a atter	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \) Yes 2 \(\overline{B}\) No	1 ☐Live birth 2 4 ☐ Pregnant at ti	Fetal death		☐Ectopic pregnancy ☐ Other (specify)			23d. Date of delivery Month Day Year			Year
J.	t the c by the achec	hys	9 Unknown	9□ Unknown									
	law requires that the death certifical as been signed by the attending phy . 2 should be detached for use as th	by	Part II. Other significant conditions con	tributing to death but	not resulting in th	e underlyin	g cause given in Pa	art I.		oacco use cont			
ဂ် ပ	w require been sign should b	iete							24a. Was a	n 24h \	b. Were autopsy findings available		
Division of Vital Records,	sician: The law certificate has l irector, page 2 s	Completed	autopsy performe 1 Tyes 22								prior to co death?	ompletion of o	ause of
<u>I</u>	ian: rtifica ctor, p	BeC	25. Was case referred to medical examiner?				26. PI	ace of Death	Check only on		L 165	200110	
<u>~</u>	Physic this ce al dire	To I	1 ☐ Yes 2 → Yo		t 2 ER/Outpa	itient 3	DOA Other: 4	Nursing Hom	e 5 Reside	nce 6 □Oth	er (Speci	ity)	
ב	ding Ph th. After th funeral	ino i	27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim Inju	ry	28c. Injury at Work?	28	8d. Describe ho				
<u>s</u>	Attending Physician: Ir death, ector: Atter this certifici by the funeral director,	icati	2 Accident investigation 3 Suicide 6 Could not be	CO. Blace (University)		М	1 ☐ Yes 2		-1 : : : : : : : : : : : : : : : : : : :				
$\overline{\geq}$	2 2 2 -	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At nome, tarm (Specify)	, street, fact	tory, office	21	Bf. Location (St City or Town	reet and Numb n, State)	er or Hur	rai Houte Num	ıber,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physical Cartifying	sician: To the best of ner: On the basis of a and manner state	examination and/o	eath occurr r investigati	ed at the lime, date ion, in my opinion, o	and place, ar death occurre	nd due to the ca d at the time, da	ause(s) and ma ate and place,	nner as	stated. to the cause(s	5)
	To the Comp	Ž	29b. Signature and title of certifier				29c. License numbe	er	2	9d. Date signe	d (Month)	, Day, Year)	
			pro 8hes	MO			000611	199	-	April,	11 3	2006	
	1)		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Ty	pe, Print)	- (./						
à	Sta	to	Jason Black MD. 31. Date filed (Month, Day, Year)	332. Registrar	's Signature	105 J	c, suite	207,	100000	7,19(1 2	1207	
	Registr		APR 0 7 2006	32. Registrar	11: 600	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Day Year Physician 2006 11:09 A April 2, Stella Willman Johnston /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 ☐ M 2 🖾 F Months 436-54-9107 April 27, 1926 Canada Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County 28a-f shov other traumatic event, If a Madical Examinar must be notified at 1 Yes 2 XNo Directo Maryland Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21009 Canada or itema 23a 20 Box Hill South Parkway Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐Yes 2 No 1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedeni's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Caroline F.L. Bickford Parsons Harvey: E. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health ar Important: If Itam 27 le eny injury or other trau once. Glenda Carol Hammell/ Daughter 3314 Midland Ct., Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 🗷 Removal from State Hillcrest Memorial Grdns 4-10-06 Seville, Ohio 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) Due to (orasia consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediale cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit T Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 🗍 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 2 No 1 Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death the Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation

Stalla #8004541151 Vital Records, P.O. Box 68760 Chinstan

Registrar

DHMH 17 Rev 1/2001

Medical

Director:

24 hours a

within 24 hor To the Fune completely fi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wa 32. Megistrar's Signature

and manner stated

net

28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)

29c. License number US0040

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

04-07-2006

Claudia A. Kroker, MD

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

ela

06-02330 Please Type or Print in Black Indelible Ink Kudrick, Kimberly State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Physician/ 1 Decedent's Name (First Middle Last) 2 Date of Death Month Day April 4, 2006 Medical Examiner Kimberly Yvonne Kudrick 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center **Bel Air** Harford Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Director 214-06-5707 39 2 X F 10/30/1966 M Usual Residence of Decedent 10c. City, Town or Location s 23a or 28a-f show re notified at once. North Hopewell PA Felton. Township 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7018 Church Road 17322 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black , or items ? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 X Married White, etc. 2 X No Yes Baltimore, MD 21215-0036
pemit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygener
Important: If iten 27 is marked other than "natural", o
injury or other tranmatic event, the Medical Examiner: 1 Yes 2 X No specify: 3 Widowed Divorced If Yes, Give Year ģ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) Homemaker Own Home 11 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Edward Howard, Sr. Virginia Yvonne 19a Informant's Name/Relationship (Type Print.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Kudrick (husband) 7018 Church Road, Felton, PA 17322 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place? 4/8/2006 Timonium, Maryland Donation 5 X Other Specify: Entombment Dulaney Valley Mem'l 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line /Medical a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last g physician and the burial - transit Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. d Physician/Medical UNPENDED AMENDED Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery use as t Live birth Ectopic pregnancy Fetal death Month past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown g Unknown the <u>о</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Division of Vital Records, Completed s been s 24a. Was an autopsy certificate has bector, page 2 sh performed? 1 ✓ Yes 2 director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? this ဂ္ ✓ Yes funeral After 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death the

23e. Did tobacco use contribute to the cause of death? Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 🗸 Yes Other Nursing Home 5 Residence 6 Other 28a. Date of Injury (Month, Day, Year) Apr 4, 2006 28d Describe how injury occurred Certification: Driver auto auto collision 15:36 Natural 1 Yes 2 V No Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State)
4207 Norrisville Road, Jarrettsville, MD (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. April 5, 2006

111 Penn Street, Baltimore, MD 21201

16:41

Maryland

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Year

Day

Country)

White

State Registrar

31. Date filed (Month, Day, Year) APR 0 7 2006

Laron Locke MD.

e and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

within 24 hours after death To the Funeral Director:

in by

		,	1 - For State Registrar	tate of Mary	land / Depai <i>Cert</i>	tment of F ificate of		Mental Hy	/giene Reg. No.	6	10893	
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Do ro + Wy	B. K'	(U 9			2. Date of D Month	Day	Year 1006	3. Time of Death	
	Examir		4a. Facility Name (If not institution, give street Village (th	4c. Count	4c. County of Death Baltimore		
	Funeral Director		Social Security Number 6. Sex	2X F 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			9. Birthp Coun Mass	place (State or Foreign ntry) achusetts	
Manyland	f show	or	10a. State 10b. County		c. City, Town or Loca		-			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No	
with the	3s or 28a	Funeral Director	Maryland Baltimore 10e. Street and Number 8832 Walther Blvd.	#323	Parkvi1	10f. Zip Code	21234		10g. Citizen of	What Coun		
5-0036 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic event, the Medical Exaction of must be notified at 2010e.	þ		Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			fispanic Origin? (San, Mexican, Puer	Specify Yes or N to Rican, etc.)	o- 14. Ra	ce - Americ ick, White,	etc.	
21215-0036 d within 72 hours aff	iene. than "natur he Medical	Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	on ompleted) College (1-4or 5+)	(Give ki	O NOT use retired	during most of wo d)	rking	16b. Kind of E			
	ntal Hygier ed other ti evant, to	Be	17. Father's Name (First, Middle, Last)	years	Coll	ege Ins	18. Mother's Na		e, Maiden Suma	ation	<u>l</u>	
Maryland	th and Meni	2	Thomas Edward Burl 19a. Informant's Name/Relationship (Type, Thomas E. Klug				and Number or R		ber, City or Town			
Baltimore,	ant of Health t: if itam 27 y or other tra		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State	Ob. Place of Disposi cemetery, crema		ce)	Date	Maryla 20c. Location	· City or To		
Baltir Permit. P	Department Important: Important: I any injury o		21. Signature of Funeral Service Licensee		New Cathe ^{22.} M	Name and Addre	ss of Facility Wiedefel	d Funer	al Home	. Inc.		
Pr	nysician		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of immediate Cause (Final disease or condition	ons that caused the ause on each line.	death. Do not enter	$6500 \cdot Yor$ the mode of dyin	k Road ng, such as cardia	Baltimo c or respiratory a	re, Mary	yland (pproxima e Interval Between Onset and Death	
E	Medical xaminer	ledical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to for as a co	nsequence of):							
Records, P.O. Box 68760, The law requires that the death certificate be executed	signed by the attending p d be detached for use as i	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3 E	ctopic pregnancy Other (specify)	7			ate of delive	ery Day Year	
rds, P	been signed b should be deta	by	Part II. Other significant conditions contrib	uting to death but no	ot resulting in the und	erlying cause giv	en in Part I.		tobacco use con Yes 20 No	-	ne cause of death?	
		Completed						24a. Was auto perfe 1 Yes	s an 24b. opsy ormad2 22 No	Were autop prior to con death? 1 \(\sum \text{Yes} \)	psy findings available npletion of cause of 2 No	
Division of Vital	After funel	Certification: To Be	Natural 5 ☐ Pending	Ra. Date of Injury (Month, Day Yea	2 ER/Outpatient ar) 28b. Time of Injury At home, farm, stree		er: 4 ursing H	28d. Describe	one) idence 6 Oti how injury occur (Street and Numi	rred		
	ours after on area bit of tilled in by		29a. Certifier 1 Certifying Physici	building, etc. (S	pecify) v knowledge, death o	occurred at the tin	ne, date and place	City or To	wn, State)	annar ac et	ated	
Div To the Hospitei or	within 24 hours after death To the Funaral Diractor: completely filled in by the	Medical	(Check only 2 Medical Examiner one) 29b. Signature and title of certifier	On the basis of exa and manner stated.	imination and/or inve	stigation, in my o	pinion, death occu	urred at the time,	date and place,	and due to	the cause(s)	
	14		30. Name and address of erson who comp			int)	3115	0 1	Apr. 1	6th	7006	
	Sta		Jeff Landr 31. Date filed (Month, Day, Year)	32. Registrar's S	FOO Wit-	the	BILD	Robe	alle V		21234	
DHMH	Registi I 17 Rev 1/2	2.	APR 0 7 200	Been	I for	W.			_			

9:50 MM.

6

		1 - For Stete Registrar	State of Marylan	d / Departme		Mental Hyg	giene 06	10894
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Las Michael 4a. Facility Name (If not institution, give 13703 Killarney	Ernest Karas		y, Town, or Location of Dea Phoenix	April	3, 2006 4c. County of Dea	
Funeral Director		5. Social Security Number 214-14-2329	Ž M 2□F 84		der 1 Year If Under 24 Hr. s Days Hours Min		25, 1922 ^{9. Bir}	thplace (State or Foreign South Carolir
BAITIMOFE, IMARYIANG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dept. Itment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show any niury or other traumatic event, the Medical Exprinest must be multipled at page.	Director	Md. Baltimo	ore Per		10g. Citizen of What C	1 ☐ Yes 2 ☐XNo		
urs after death	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates:	ì	21236 cedent of Hispanic Origin? (coeffy Cuban, Mexican, Pue 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	erican Indian,
Maryland 4 14 15-0050 d 2 should be filed within 72 hours af th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exprin	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)		sual Occupation work done during most of we use retired) Of Finance		16b. Kind of Business	,
rylariu hould be filt d Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last) Ernest Karas 19a. Informant's Name/Relationship (19h Mailing Addre	18. Mother's Na Thelr ass (Street and Number or F		is	Zin Code)
re, mar s 1 and 2 si r Health an item 27 is r		Annette Karas/ W	life 20b. F	-	ispillion Rd.			1236
Definition of permit. Pages 1 ar Deportment of Heal Important: If item 2 in prize of them 2 in prize of the pages.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licer	St.	. Demetrio	S Cem. 4-8	8-06 eral Hom	Cub Hil	1, Md.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ilcal Examiner	23a. Part1. Enter the dilease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the total one cause on each line. Due to (or as a consect of total or as a consect or as a consect of total or as a consect or as a c	th. Do not enter the many tension of the many	ode of dying, such as cardia			Approximate Interval Between Onset and Death
hat the death certifical that the death certifical by the attending phydetached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 □Ectopic	pregnancy (specify)		23d. Date of de Month	elivery Day Year
wrequires that the second of t	ed by Ph	Part II. Other significant conditions of CONUNMY AMTEM REMAINS	contributing to death but not res		Did tobacco use contribute to the cause of death			
UNISION OF VICE THE COLOS, if or Attending Physician: The law requires taller death. Director: After this certificate has been signed in by the funeral director, page 2 should be to	e Complet	ZYMMZ US STMM 25. Was case referred to medical	CAUL AUIMU	WMMY DISE			prior to death? 2 \(\)\(\)\(\)\(\)\(\)\(\)\(\)\(utopsy findings available completion of cause of s
y II /sicia s certi	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	Other	eath Check on o	ne) tence 6 Other (So	ptrs Reside
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	· · · · · · · · · · · · · · · · · · ·	ome 5 ☐ Residence 6 ☐ Cother (Specify) UTS REST 28d. Describe how injury occurred			
DIVI spital or At ours after d larat Direct filled in by		4 Homicide determined		fy)		City or Tow		
e Hos 24 h Fun letely	Medical	(Check only 2 Medical Exer	niner: On the basis of examination and manner stated.	ation and/or investigat	ion, in my opinion, death occ	curred at the time,	date and place, and du	e to the cause(s)
To the To the To the comp	Me	29b. Signature and title of certifier	mo		29c. License number		29d. Date signed (Mon APAIL 4)	
8+1		30. Name and address of person who	SWIT MD SE	OI LOCH RA	IVEN BLUD B	PALT, MD	21239	
St Regis	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature Angel				

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ,200 09 AM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner ohn MUILL If Under 24 Hrs. Age (In yrs. Social Security Numb 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min Year) Months Hours Director 226-48-0862 April 10,1939 VA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ahow the Mudical Examiner must be notified at n/a MD Baltimore 1 ☐Yes 2 No Directo the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1441 North Lakewood Avenue 238 21213 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 212 No blaCK Specify ۵ 3 ☐ Widowed 4 1 2 2 ivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Restaurantuer Restaurant permit. Pages 1 end 2 should be filles. Department of Health and Mental Hermontant: if item 27 is meany injury or other. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert King Maria Banks ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Fairfield Drive, King William VA 23086 William King /Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rock Spring Cem. 3/30/2006 Manquin, 4 ☐ Donation 5 ☐ Other (Specify) neral Service Licensee Victor 21. Signature of Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death \ one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** MIN /Medical Due to (or as a consequence of) Examiner Squamous cell carcinoma Sequentially list or citius if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 <u>years</u> Due to (or as a consequence of): The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Box 68760 by Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4 Pregnant at time of death Day 5 Other (specify) ed by the Ö 9□ Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Gunknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed Division of Vital 21 No 1 ☐ Yes 2 ☐ No 1 Yes Attending Physician: 25. Was case referred to medical examiner?
1 √Yes 2 No Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manger of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1. Natural 5 Pending 1 □ Yes 2 □ No 2 Accident investigation To the Hospital or Atterwithin 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) R.85860 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and Street Ballomore, Maryland 21287 u 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 7 2006

			State of Maryland / C For State Registrar	Depar	rtment o		and M	lental Hy		06	1089	16
	Physici	an	1. Decedent's Name (First, Middle, Last) Mabel Jean Lay					2. Date of Dea Month April	Day	006 ^{Year}	3. Time of 0	Death M
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center			m, or Location linster	of Death	APITI	4c. Cou	unty of Deat		
	Funeral Director		5. Social Security Number $220-74-0943$ 6. Sex $1 \square M 2 \cancel{N} = 7$. Age (In yrs. last birt 74 Usual Residence of Decedent		If Under 1 Y Months Da	ear If Unde ays Hours	r 24 Hrs. Min.	8. Date of Birt (Month, Day June 26	y, Year) 1931	9. Birt Co PA	thplace (State or ountry)	Foreign
Maryland	r 28a-f show routilied at	tor	10a. State 10b. County 10c. City, Town Westin								10d. Inside City 1 ☐ Yes	-
th with the	23a or 28a ust be not	al Director	10e. Street and Number 2002 Don Avenue		10f. Zip Co. 2115	57			10g. Citizen USA			
036 ours after dea	and Mental Hygiene. Is marked other than "natural", or Itama 23a or 28a-f show raumatic event, Ita Madical Examinar must be notified at	by Funeral	11. Marital Status 1		as Decedent Yes, specify			ecify Yes or No- Rican, etc.)		Black, Whit	erican Indian, te, etc. hite	
Baltimore, Maryland 21215-0036	Department or Health and Mental Hyglene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, <u>Ita Madical</u> <u>once.</u>	Completed	Flementary/Secondary (0-12) College (1-4015+)		ent's Usual O ind of work d O NOT use re r WOTk	ccupation one during mo etired) Ced	st of worki	ng	16b. Kind o	of Business	/Industry	
land Suld be filed	Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Raymond S. Lay	18. Mother's Name (First, Middle, Maiden Sumame, Alma Lebo						name)		
, Mary and 2 sho	ealth and h n 27 is ma ier trauma		Dorothy Lay (sister) 200	002 D	on Ave	e., Wes	tmins	al Route Numberster, Mc	1 2115	7		
timore L. Pages 1	rtment of H rtant: If Iter sjury or oth		4 Donation 5 Other (Specify)	ery, crema een	atory or other Memori	al	4-6-0		inksb	urg, l		1
Balt permit.	Depar Depar Impor		21. Signature of Funeral Service Licensee Parige Hought Funeral Home & Chap P.O. Box 195 Sykesville, Md 21784									L
	ysician Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	not enter	the mode of	dying, such a farctiv	s cardiac c	or respiratory a	rest,		Approximate Interval Betwoonset and D	veen Death
60, be executed	g physicien and as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen	of):	ary.	Artery	Dis	ease			Years	
vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate	the attendir hed for use	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 1 □ Pregnant at time of death 1		Ectopic pregn Other (specif				23d	. Date of de Month		'ear
rds, P.	6 g		Part II. Other significant conditions contributing to death but not resulting in Newtal Retardstim	in the unc	derlying caus	e given in Part	11.		obacco use		o the cause of de	
Division of Vital Records, or Attending Physician: The law requires t	ate hes been s page 2 should	Completed	Hypertension					24a. Was autop perfo	rmed?	death?	utopsy findings a completion of ca s 25 No	available ause of
Vita sician:	certificate irector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	utnationt	3[] DOA	Othor		h (Check only o		Other (Sou	acity)	
ion of	within 24 hours after death. To the Funeral Director: After this certificate hu completely filled in by the funeral director, page	ation: To	27. Manner of Death 28a. Date of Injury 28b. 1	Time of Injury		Injury at Work? 1 Yes 2		28d. Describe			Scriy)	
Divis ital or Atte	within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 289. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural in City or Town, State)							lural Route Numb	ber,	
Div To the Hospital or	24 hou	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	ie, death i nd/or inve	occurred at t estigation, in	he time, date a my opinion, de	and place, eath occuri	and due to the red at the time,	cause(s) and date and pla	d manner a ace, and du	s stated. e to the cause(s))
Tot	withi To tl	×	29b. Signature and little of certifier M Yeon M			3368					th, Day, Year)	
	H		30. Name and address of person to completed cause of death (Item 23a) No. 1380 Progr 31. Date filed (Month, Day, Year) 32. Registrar's Signature	(Type, P	Way,	, Suite	114	Elder	sburg	mo	21784	
рнмн	Sta Registi	ar	APR 0 7 2006		A)							
1			OF	RIGIN	IAL							

Physicia /Medica Examine

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Unpend item# 25 1- For State Registrar	,		rtificate					Reg. No.	00	100	91
	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ıth Day	Vane	3. Time o	
	James Cr	aig I	Llinas					"Marc	ch 530,	, 2006	1:45	P
	4a. Facility Name (If not institution, give 1 Hilltop Court	street and number)	-	4b. City, T	own, or apol		of Death			unty of Death Anne Ar		
Ą	5. Social Security Number 6. Se	7 400 //0.1	yrs. last birthday)	If Under 1		If Under	24 Hrs.	8. Date of Birtl			place (State	or Form
	204-60-4043	37 37 37	Yrs.		Days	Hours	Min.	(Month, Day	, Year) , 196	Cou	lorida	
	Usual Residence of Decedent 10a. State 10b. County	10c	City, Town or Lo	ncation							10d. Inside C	ity Limi
	MD Anne Aru		nnapoli								1 ₹ Yes	
-	10e. Sireet and Number			10f. Zip C						of What Cou	ntry?	
	1 Hilltop Court				403		:-0 (0-			SA		
	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decede If Yes, specif	nt of His ly Cuban	spanic Ori n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,		
	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 🖺 No If Yes, Give Year or Dates:		1X Yes 2	□ No	Specify:	Mex	ican	Sp	ecity: Mex	cican	
	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Dece (Give life.	dent's Usual kind of work DO NOT use	Occupa done di retired)	ition <i>uring</i> mosi	of worki	ing	16b. Kind	of Business/Ir	dustry	
	Elementary/Secondary (0-12)	College (1-4or 5+)	Ваз	ctende	r				Resta	aurant		
	17. Father's Name (First, Middle, Last)							(First, Middle,	Maiden Su	mame)	_	
	James Llinas	and a second	401 11		/2:			anchez				
	19a. Informant's Name/Relationship (T)							al Route Numbe				
	James Llinas/Fathe		b. Place of Dispo			Lane		11iamsv: Date		NY 14	+221	
	1 ☐ Burial 21X Cremation 3 ☐ F	Removal from State	cemetery, cre	matory or oth	er place							
i	4 □Donation 5 □ Other (Specify)		Mt. Calv							ktowaga		
	21. Sign ture of Juneral Service Licens	of Athin	2	2. Name and	Address	s of Facilit	le 16 Wi	rna-Pel 71 Maplo 11iamsv:	legri e Road ille.	no Fune d NY 14	eral но 1221	ome
	23a. Part1. Enter the disease, or comp	lications that caused the c	leath. Do not en	ter the mode	of dying	, such as					Approximating Interval Bet	
	shock, or heart failure. List only o Immediate Cause (Final	Complication	e of chro	nic alco	sholi	CTT.					Onset and	
	disease or condition resulting in death)	a. Due to (or as a con		iic aicc	MIOJI.	i Silii						
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a son	sequenes of):									
	that initiated events	С.										
	resulting in death) Last	Due to (or as a con	sequence of):									
1	IF FEMALE:	a										
	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	egnancy Fetal death 3[⊒Ectopic pre	gnancy				23d	I. Date of deliv Month	,	Year
	1 Yes 2 No	4☐Pregnant at time 9☐ Unknown	of death 5[Other (spe	cify)					MONIT	Day	1041
	Part II. Other significant conditions co	ntributing to death but not	resulling in the u	inderlying car	use give	n in Part I.		23e. Did to	bacco use	contribute to t	he cause of o	death?
								1 □ Y	es 2 1	lo 3 Pro	bably 4 🗍	Unknov
								24a. Was	an 2	4b. Were auto	opsy findings	availat
								autop	med?	death?	2∐ No	cause c
	25. Was case referred to medical					26, Place	of Death	1 (Check only o	2□ No ne)	. Д 105	20 140	
	examiner?	Hospital:	2 ER/Outpatie	ni 3 DOA	Othe	C		me 5 Resid		Other (Speci	at so	cene
	27. Manner of Death	28a. Date of Injury (Month, Day Yea.	28b. Time o		c. Injury Work			28d. Describe h			//	
	1. Natural 5 ☐ Pending 2 ☐ Accident investigation	(WOIIII, Day 19a.	r) Injury	м		r res 2 🗆	No					
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	Al home, farm, st ecify)	reet, factory,	office			28f. Location (S City or Tow		lumber or Run	al Route Num	nber,
	29a. Certifier 1 ☐ Certifying Phy (Check only one) Medical Example 1	rsician: To the best of my iner: On the basis of examend manner stated.	knowledge, deat nination and/or in	th occurred a avestigation, i	t the time	e, date an inion, dea	d place, a	and due to the ded at the time, d	cause(s) an date and pla	d manner as s	stated. o the cause(s	s)
	29b. Signature and title of certifier			29c.	License	number			29d. Date s	igned (Month,	Day, Year)	
	> (and of the	ellan n	A		0.C.	M.E.		M	arch :	31, 200	06	

State Registrar

31. Date filed (Month, Day, Year) APR 0 7 2006

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#14, perFH, C854, 4///0 TT State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Month April Physician Yea 5, 4:35 AM Ladislao A. Lopez /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/07/1948 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 ☐ F 57 Yrs. Director 149-36-2345 NY Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-1 show Item 27 is marked other than "natural", or items 23a or 28a-f shov othar traumatic event. The Nacional Examinar must be notified at 1 Yes 2 No Director MD Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 21215 4637 Park Heights Ave. Apt. 704 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Cuban Specify: Hispanic 1 Yes 2□ No Specify: þ 3 ☐ Widowed 4 MDivorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Dept. of Public Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Worker Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Eduardo Lopez Margaret Peggy Burgeress 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 soft Health and 1 tem 27 le Margeaux Lopez/Daughter 4632 Riddle Drive Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 2006 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives EPPIOM L 8717 Green Pastures Drive Baltimore, Maryland Keller a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** months nepatocelular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conflicting if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine as the burial-transit resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 🗆 No 1 ☐ Yes 2, 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) + 5 1 CL 1 Yes 2 No 2 ER/Outpatient 3□ DOA 1 🗌 Inpalient 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident al or Attence after death Director: filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner slated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 1724170 o MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year)

schey

NEutawst Hospice gistrar's Signature

2 should be filed within 72 hours after and Mental Hygiene.

AD151A0

P.O. Box 68760.

Vital

ŏ

Division

Attending Physician:

death.

		•	For State Registrar	State of Marylar		tment of H			ene 0 0 6	10899
at g		_	Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	ysicia Aedic	-	Fran	ces r	nart	in		April	3. 2006	, 8:00A M
	amin		4a. Facility Name (If not institution, give st 3205 Dor	reet and number) -chestor	Rd.	4b. City, Town, o	Location of Deat	noie	4c. County of Death	7
Fun			5. Social Security Number 6. Sex 21 9-32-9452	M 2 F 7. Age (In yrs.	(ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		(ear) 9. Birth	hplace (State or Foreign untry)
ס		Ĩ	Usual Residence of Decedent					1	7 0 000	
Aarylar I ehow	18 28	- 1	10a. State 10b. County	10c. Ci	ty, Town or Loca	ation	moil			10d. Inside City Limits 1 Yes 2 □ No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23s or 28s-1 ehow	pe notif	<u> </u>	10e. Street and Number	-heats	Rd.	10f. Zip Code	10.5	100	g. Citizen of What Cor	yntry?
death death	R DIASI	Funeral	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	J.S. 13. W	as Decedent of H	ispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
036 ours after al', or Ite	Examine	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		☐ Yes 215 No	Specify:	is mount of one	Specify:	Lack
15-003 in 72 hours n "natural",	Acdical	Completed	15. Decedent's Educ. (Specify only highest grade	completed)	(Give ki	nt's Usual Occup ind of work done O NOT use retired	during most of wo		Sb. Kind of Business/I	1
2121 ed within /giene.	ag .	E Co	Elementary/Secondary (0-12)	College (1-4or 5+)	Dmv.	Custo			notor veh	icle - DiCa
aryland 2 should be filed and Mental Hygi marked other	ilc eveni	To Be	17. Father's Name (First, Middle, Last)	earson			18. Mother's Nar	me (First, Middle, Ma	iden Sumame) EPI	05
Maryla d 2 should I th and Men	traumat		19a. Informant's Name/Relationship (Typ	e, Print) Son	19b. Mailing	Address (Street	-1	4.0.1	City or Town, State, Z	(ip Code) 4,30253
Itimore, M It. Pages 1 and 3 Itment of Health Itant: If Item 27	or other	ľ	20a. Method of Disposition 1 Øgurial 2 □ Cremation 3 □ Re	l ,		tion (Name of atory or other place	(9)	Date 20	Oc. Location - City or 1	
Baltimo permit. Pag Department Important: I	any Injury once.	1	4 Donation 5 Other (Specify) 21. Signatur of uneral rvic License	C		HLL (rea BUS	mie mai
<u>ක සියීම්</u>	a a		23a. Pan1 Enjer the disease, or complic	ations that caused the dear			narch t			Sproximate
Physic	ian		shock, of heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	2D/AZ		LC00			Interval Between Onset and Death
/Med Exami			resulting in death)	Due to (or as a consec	quence of):			<u> </u>		2(100
V B	ii.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):	5 (OIM				2923.
cate be executed	rial-tran	Exal	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):					
\$8760 icate be e	s the bu	dicai	d.							
Box 6 leath certifi attending	r use a	an/We	230. Was decedent pregnant	c. If yes, outcome of pregn 1□Live birth 2□Feta		ctopic pregnancy	,		23d. Date of deli	
, P.O. E that the dea	ached fo	Physician/Me	in the past 12 months? 1 ☐ Yes ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□ Unknown	death 5 🗆 (Other (specify)			Month	Day Year
I Records, P.O. Box 6 The law requires that the death certifit site has been signed by the attending I	e P	2	Part II. Other significant conditions cont	ributing to death but not res	sulting in the unc	dertying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	
Records, he law requires to a has been signer.	CI	Completed						24a. Was an autopsy	prior to c	topsy findings available completion of cause of
Vital Rician: The certificete h								performe 1 ☐ Yes 2		2 X No
Vital sician: 1	recto	m	25. Was case referred to medical examiner?	espital:	EB/Outpetient	3□ DOA Oth	er	ath (Check only one)	6 COther (C	-4.1
ng Ph	ıneral	lon: To	27. Menn r of Death 1 latural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe how	ce 6 Other (Spec	:ny)
DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	n by the	Certification:	Calcident investigation Calcident investigation Calcident investigation Calcident investigation Calcident investigation Calcident investigation Calcident investigation	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree fy)		163 2 110	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
ospital c	completely filled in		29a. Certifier Certifying Physi	cian: To the best of my kno	owledge, death	occurred at the tin	ne, date and place	a, and due to the cau	se(s) and manner as	stated.
the H hin 24 the F	nplete	Medical	one)	and manner stated.	ation and/or inve					
Twit of	8	The same of the sa	29b. Signature and title of certifier	andmo		29c. Licens	00617	(0)	Date signed (Month	•
	10		30. Name and address of person who con	npleted cause of death (Item					MORE, MA	5, 2006
	Y			980-, MID	24	00 KIR	2K Avi	E BAUT	more ma	YEAND
Re	Stat gistra	-	31. Date filed (Month, Day, Year) APR 0 7 20	32. Redistrar's Sign	ature de la constant	cole				

			riease	Chata of Manda				=	_	
			for State	State of Maryla				ientai Hygie	ene 0 0 6	0900
			1 - State Registrar		Cei	rtificate of	Death		ı. No.	
	Physici	an	Decedent's Name (First, Middle, Las	1 E, 1	ΛΛ	- (Date of Death Month	Day Year	3. Time of Death
	/Media		Mari	1 6, 1	rige	15		April	2006	502 AM
	Examir	ner	4a. Facility Name (If not institution, give		1	_	r Location of Death		4c. County of Death	
			Franklin Square			12050			Baltin	ore
	Funeral		5. Social Security Number 6. So	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign ntry)
	Director		0000	7	Yrs.			Nov. 4,	1929 MI	aryland
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	Aaryl aho	5	ma	1/0	2	a oti	21 410	,		1 Kes 2 No
	with the Maryland a or 28a-f ahow	Director	10e. Street and Number	Aptie	- /	10f. Zip Code	71000	100	. Citizen of What Cou	nt n O
	With	Ö	5757 H	970/1000	od Cr	7 17	01	100	/ / C	4
15.7	death with the Maryland ima 23a or 28a-f ahow r.mat Le notified at	Funeral	11. Marital Status	12. Was Decedent Ever in t	15 13	Was Decedent of H	lispanic Origin? (Spe	acity Yes or No-	14. Race - Ameri	can Indian
T.		Fun	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White	
)38 38	hours after tural', or the	by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	plack,
, $\mathcal{M}_{\mathcal{Q}\mathcal{C}\mathcal{Y}}$ and 21215-003	2 hou	Completed	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Business/Ir	dustry
3 5	within 72 ene. than "nat	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of works	ng	Commu.	117
7 2	filed with Hygiene. other than	Eo	12+4	2/4	Ke	eestio-	715t		C	ade
2	be filed winter Hygien of other the	BeC	17. Father's Name (First, Middle, Last)	1 //			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>a</u>	should be nd Mental marked o	To B	William	Haught	DN		Kubn	Hai	1 gh ton	
S Mary	d 2 should it th and Meni ?7 is marke treumatic	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Number or P	I Route Number, (City or Town, State, Zi	Code)
	C = 14 F		Beverly Pugh-	neice	8418	Rockman	T. Rd R	osedale	md, 21:	237
M_{Ver} Baltimore,	s 1 and of Healt		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place			c. Location - City or T	
√ E	permit. Pages Department of i important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval hom State	etro	(remain		7-06 (a tone il	10 md.
₹	permit. Departmimporta	1	21. Signatur vo Funeral Service Licen			2. Name and Addres	A	o Fredt	FILTION PO	Car
≺ ä	Departimbe		Smill / M	me	6	11. P.n	rarch F.	+ 30	eto, md.	21229
			23a. Part1. Into the disease, or comp	olications that caused the dea	ith. Do not ent					Approximate
			shock, or leart failure. List only in Immediate ause (Final disease o condition	0		0				Interval Between Onset and Death
	Prrysician /Medical		disease of condition resulting in death)	Due to (or as a conse	SCUI	ar He	cident	200		
	Examiner			Due to (or as a conse	quence oi).					
		ē	Sequentially list conditions,	b. Due to (or as a conse	quence of):					
14	uted J ansit	Examiner	Sequentially list conditions, if any, leading to innirediate cause. Enter Underlying Cause (Disease or injury that initiated events							
`~	e be executed /sicien and e burial-transit	Exa	resulting in death) Last	C. Due to (or as a conse	quence of):					
760,	te be ex ysicien e buria	cail		d						
.89				J						
×	eath certificat ettending phy for use as the	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					23d. Date of deliv	erv
ă	leath ette	cia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of]Ectopic pregnancy] Other (specify)	′		Month	Day Year
o.	that the de the by the c	ysi	9 Unknown	9□ Unknown						
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifical refers. Setor: After this certificate has been signed by the ettending phy the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Sp	uires n sign	Q P	Methicillin resistan	t. Stophylococo	cus ac	reus bo	acteremie	1 □Yes	2 No 3 Pro	oably 4 ∐Unknown
ō	w require been si should t	lete		• •				~		aneu findinge available
Re	he lav e has ge 2	Ę	abdominal aor	tic aneur	ysm_	, hyper	tension	autopsy performe	prior to co	ppsy findings available impletion of cause of
<u>a</u>	sicien: The la certificate ha irector, page 2		25. Was case referred to medical					1 ☐ Yes 25		2 □ No
Ξ	ysician: is certific director,	Be	examiner?	Hospital:	3.50.0	oth	0.0	(Check only one)		
ō	Phys raldi	2	27. Manner of Death	1 Inpatient 2	28b. Time of	IL 3L DOA	4 Linuising Ho	me 5∐ Residend 28d. Describe how	e 6 ☐Other (Speci	(y)
u	ding R th. After funer	ig	1 Natural 5 ☐ Pending	28a. Ste of Injury (Month, Day Year)	Injury	Worl	k? Yes 2□No	200. 20001100 11011	inquity occurred	
<u></u>	deat deat ctor: y the	lica	3 Suicide 6 Could not be		nome farm str			28f Location /Stre	et and Number or Run	al Route Number
Ö.	after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spec	ify)	out, radioly, dilloo		City or Town,	State)	27710010110111001,
	To the Hospital or Attendin within 24 hours after death to the Funeral Director: Att completely filled in by the fun	C	29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledge deat	h occurred at the tin	ne date and place	and due to the cau	se(s) and manner as	tated
	24 h 24 h Fur etely	Medicai	(Check only 2 Medical Examone)	iner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death occurr	ed at the time, date	and place, and due t	o the cause(s)
	vithin o th	Me	29b. Signature and title of certifier			29c. Licens	e number	290	I. Date signed (Month,	Day, Year)
	->-0		Wassin	D-11+	MA	RES	00000	0 4	1/1/06	,
	1		30. Name and address of person who o	completed cause of death /Ite	m 23a) (Tvoe					
	\	13	Diz wassim El-Hitt				altimore	mo	21237	-
	Sta	ite	31. Date filed (Month. Day, Year)	32 Registrar's Sign		ask D				
	Dest		APR (1 7 20	ilh 1 Frank Jane 1 A	30	AL STATE OF THE ST				

		1 - For Stata Registrar	State of Marylar	·	nt of Health and te of Death	d Mental Hygie	600	10901
Physici		1. Decedent's Name (First, Middle, La	1AD150N			2. Date of Death	Pay 2000	3. Time of Death
/Medic Examir	er	4a. Facility Name (If not institution, given the DN SECOUNE)	to street and number) 324 HOSDITAL G	AUGO ST !	y, Town, or Location of Do BALTINOON1	E MID 21793	4c. County of Death	
Funeral Director		5. Social Security Number 3. 16.17 Usual Residence of Decedent	Sex 7. Age (In yrs.	- Yrs. If Und	er 1 Year If Under 24 H s Days Hours N	Ain. (Month, Day, Y	(ear) 9. Birth	place (State or Foreign ntry)
Maryland	ctor	10a. State 10b. County	10c. Cit	y, Town or Location Saltin	IDre_			10d. Inside City Limits 1 ✓ Yes 2 ☐ No
ath with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 934 N. Be	ntalou S	st,	21216		. Citizen of What Cou	
036 urs after dei ul; or items	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:		edent of Hispanic Origin? ecify Cuban, Mexican, Pu 2 X No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White	
alfimore, Maryland 21215-0036 nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Heath and Mental Hygiene. artment of Heath and Mental Hygiene. artment of Heath and Mental Hygiene are selected to the selected of the selected to the selected t	Completed	15. Decedent's Elementa py/Secondary (0-12)		16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of	working	b. Kind of Business/Ir	
laryland 2121 2 should be filed within and Mental Hygiene, is marked other than aumatic event, the Ma	To Be Co	17. Father's Name (First, Middle, Las. Emory Am	00 1:	son	18. Mother's	Name (First, Middle, Ma	OFT HOLD iden Sumame)	abird
ore, Maryland ss 1 and 2 should be filt of Health and Mental Hy litem 27 is marked oth r other traumatic even		19a. Informant's N-me/Relationship	Type, Print) (wife)	19b. Mailing Addre	A Company of the Comp	ou St. I	City or Town, State, Zi	d.21216
Baltimore, permit. Pages 1 ar Department of Hea Important: If item any injury or othe once.	S. S. S. S. S. S. S. S. S. S. S. S. S. S	20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Special Service)	Removal from State (fy)	Place of Disposition (Nemetery, crematory of	FD (est 4	12/2006 0	wings N	Mills, Md.
Dan Permi Depa Impo		Joseph	J. Kus		and Address of Facility			P.A. 1216 Approximate
Physician /Medical	100	23a. Pan'i Enter the disease, or con shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. SERSIS	?	ode or dying, such as care	diac or respiratory arrest		Interval Between Onset and Death Houng
Examiner	J.,	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of the consequence o	IONIA	10.00			DAGS
68760, cate be executed physician and street transit	ai Examiner	r any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq					
ecords, P.O. Box 68760, ————————————————————————————————————	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregni 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d 9 ☐ Unknown	il death 3 ⊟Ectopic			23d. Date of deliv	ery Day Year
cords, P. wrequires that the second signed by should be detailed.		Part II. Other significant conditions CONUMARY AND	_		_		cco use contribute to s	the cause of death?
The tate h	Completed by	HYPENTENSIER HYPENLIPIDE		STYPE	<u> </u>	24a. Was an autopsy performe	24b. Were autoprior to codeath?	opsy findings available ompletion of cause of
of Vital F Physician: Th this certificate ral director, pag	To Be (25. Was case referred to medical examiner? 1 ☐ Yes _ 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ 0	Out	Death (Check only one)	ce 6 ⊡Other (Speci	(v)
Sion of Vita tending Physician: Jeath. tor: After this certific the funeral director,		27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how		
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		ome, farm, street, factory)	ory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical		nysician: To the best of my kno miner: On the basis of examina and manner stated.					
To the within To the comp	M	29b. Signature and title of certifier	nopike, n		9c. License number		Date signed (Month,	
(3)		30. Name and address of person who		n 23a) (Type, Print)	GAZZIMANE S	T ASPLTIM	me, MD	21334
Sta Regist	_	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	· · · -			

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Bernice Guenelle McWhorter March 30, 2006 8:43 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Baltimore Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov.1,1924 Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F 81 Yrs. Director 382-22-4810 KY Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show le marked other than "naturel", or Items 23s or 28s-1 ebor sumstic event, the Madical Exeminer must be notified at 1 X Yes 2 No Directo Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10310 Swift Stream Place #205 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No δ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked ery Injury or other traumatic evonce. John Moren Irene Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Sue Judd/Daughter 10310 Swift Stream Place #205 Columbia, MD 21044 20b. Place of Disposition (Name of cometery, crematory or other particles of the particles 20a. Method of Disposition 20c. Location - City or Town, State St. Clair Twp., 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Apr.4,2006 4 ☐ Donation 5 ☐ Other (Specify) Butler County, Ohio Cemetery Brown-Dawson Funeral Home 330 Pershing Ayenue Hamilton, OH 45011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 10min 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8 etween Onset and Death Immediate Cause (Final disease or condition resulting in death) Cirrhosis **Physician** Idiopathic years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or se a nonecquanna of): Examine certificate be executed burial-transit physicien and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai as the nding IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months? 1 Tyes 2 2No Day Month Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No should should Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an page 5 autopsy performed? certificate 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence Denther (Specify) NO > PI @ 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 march 30 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST Barne un 21204 CHARLES, NO 6601 AARON 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 0 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend PI, item# 23ab parting 085th 4/7/06 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Rown, or Location of Death Examiner If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** 220-10-8906 Months Days 1 M 2 F Hours Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other then "naturel", or iteme 23a or 28a-1 show or other traumatic event, II m Medical Exacts at any inclified at 1 Yes 2 No Completed by Funeral Director Timore moniu 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 620 403 12. Was Decedent Ever in U.S. Armer Forces? 1 DYes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Newer Married 2 ☐ Married 1 ☐ Yes 2 🖫 No Specify: White Specify: If Yes, Give Year or Dates: NAVY 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use refined) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) naintenanc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)Un + 403 MO 21093 Health a Imonium Ob. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - Vity or Town, State Pages 1 1 □ Burial 2 ☑ Cremation 3 □ Removal from State Evans huneral Chape 4 ☐ Donation 5 ☐ Other (Specify) orest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hernatives Funeral and Cremation eny ir 101Krd behevore Mmonium, mo 21093 atriciacam Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Aspiration pneumonia Immediate Cause (Final disease or condition resulting in death) **Physician** weeks neumania /Medical Due to (or as a consequence of): Examiner Piration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as the the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 4 Pregnant at time of death ☐Yes 2☐No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? cete hes by page 2 s this certificate | 2□ No 1 🗌 Yes 2 No 1 ☐ Yes Division of Vital : After this certifice funeral director, [or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No within 24 hours after deam.
To the Funeral Director: / 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 y 5006 arch and address of person who completed cause of death (Item 23a) (Type, Print) ERNESTINE WRIGHT 2300 DULANEY VALLEY ROAD TIMONIUM 21093 MD 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State APR 0 7 2006 Registrar

10:50

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician Charles Junior Moon 12:15 A April 1, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Manor Care Chevy Chase Chevy Chase 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F Yrs August 8, 1915 579-14-7079 90 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a State r 28a-f show 1 ☐ Yes 2X No Chevy Chase Maryland Montgomery Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Iteme 23s or the Medical Examiner must be 20815 United States 8700 Jones Mill Road Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Precision Instrument Specialist Federal Government event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liquy or other traumatic event size. Be Jennie Sennett ဥ Charles Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Edgewater Lane, Rochester, NY 14617 Laura W. Moon/sister-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) April 6, 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc
7557 Wisconsin Avenue, Bethesda, MD 20814 21. Signature of Funeral Service License tems ares M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Multi Organ Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consucrence of). Examiner physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) be detached Division of Vital Records, P.O. 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 1 Unknown Decubitus been si should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2**K** No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ဥ 1 ☐ Yes 2 🔯 No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending ours after death. neral Director: Aft filled in by the fur 1 Tes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} hours after within 24 hours a To the Funeral C TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 9 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 960 April 3, 2006 mah 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road #202, Gaithersburg, Maryland Raman R. Tuli, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 7 2006

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2006^{×ear} **Physician** April 3 4:20P Louise Lunger Meyers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Retirement Community Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 1922 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X**XF Months Days Hours Min 84 Pennsylvania 187-12-3734 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits **Worle** ?7 is marked other then "naturel", or iteme 23a or 28a-f ebov traumatic event, it e Middoll Examiner must be notified at 1 ☐ Yes 2√√No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane 21228 USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: if item 27 is marked other then "naturel", or items 23. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 200 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Marned 1 Tes XX No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: White XX Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Automobile 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Curtis Eugene Lunger Edith Margaret Shepperson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) 19a. Informant's Name/Relationship (Type, Print) Niece Michele Whelan 2303 East Aurora Avenue DesMoines Iowa 50317 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: if it eny injury or o ☐ Burial 2XXCremation 3 ☐ Removal from State 4/6/06 GreenMount Cemetery Baltimore, Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ignature of Funeral S 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Adenocarcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events iding physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 XX nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 🔏 No certificate 1 ☐ Yes XX No Be 25. Was case referred to medical 26. Place of Death Check only one) Hospital: Other: XX Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 📉 o Certification: To 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours 29a. Certifier 1 XX contitying Physician: To the best of my knowledge, death occurred at the time. Sate and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D30989 April 4, 2006 30. Name and a Press of person who completed cause of eath (Item 23a) (Type, Print) Myla M Carpenter MD 711 Maiden Choice Lane Catonsville Md 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 0 7 2006

1 - State Registrar

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Α.

4a. Facility Name (If not institution, give street and number)

Monroe

Lolita

	Director		218-90-5	584	□M 2【 X F	43	Y	rs. Mon	hs Da	ys Hours	Min.	(Month, D L 0 / 06			land
	p >		Usual Residence of 10a, State	Decedent 10b, County		100 C	ity Tour	or Location							10d. Inside City Limits
	Maryla -f ehov fied et	tor	Maryland	Tob. County		100.0	-	ltimor	e						1 X Yes 2 No
	3s or 28s	i Director	10e. Street and Nur	mber addish A	vanua			10f.	Zip Cod	21216				S.A.	ountry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 ehow other traumatic event, the Madical Exam per must be notified at	by Funeral	11. Marital Status	ed 2 Married	12. Was Dece Armed For 1 Tyes If Yes, Give Year or Da	ces? 2 📉 No e	J.S.	If Yes,	ecedent specify (s 2X	of Hispanic Orig Cuban, Mexican	gin? (Specif , Puerto Ric	y Yes or N an, etc.)		14. Race - Ame Black, Whi Specify: B1	te, etc.
15-0	"natur	leted	(Spec	15. Decedent's Edufy only highest gra			16a. i	Decedent's C Give kind o	Jsual Od	ccupation one during most stired)	of working		16b. K	and of Business	/Industry
21215-0036	d within giene. or than "	Completed	Elementary/Seco	ndary (0-12)	College (1-	-4or 5+)		ırses					Me	edical	
Maryland	wild be filted whental Hygie arked other intic event, It	To Be (17. Father's Name							18. Mothe			e, Maider	Sumame)	
	and 2 shoulealth and Mm 27 is mark		19a. Informant's Na Snowdie	ame/Relationship (Jones / N			10:	26 Bra	ddi	sh Aven				or Town, State, Marylai	Zip Code) nd 21216
Baltimore,	Pages 1 nent of He ant: if iten ary or oth			osition Cremation 3 5 Other (Specif		State	cemetery	Disposition crematory on Cen	or other	place)	Date 4/11/2			ocation - City or dsdowne	Town, State , Maryland
Balt	permit. Pages Department of h important: if ite any injury or of		21. Synature of Fu	neral Service Licer	nsee C										F/H, P.A. yland 21215
8	Physician		23a. Part1. Enter the shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List only (Final	one cause on ea	nused the dea ach line.				Preumo		espiratory	arrest,		Approximate Interval Between Onset and Death
V	death certificate be executed We diending physician and defor use as the burial-transit	Jicai Examiner	Sequentially list confrant, leading to imcause. Enter Unde Cause (Disease or that initiated events resulting in death) I	imediate orlying injury	b. Due to (c	or as a conse	чиенсе о): 							3 menths
P.O. Box 68760,	the death certific y the ettending p ched for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months? ☐No		nth 2 ☐ Fet ant at time of	at death	3 DEctop						23d. Date of de Month	liv <i>e</i> ry Day Year
ecords, P.	w requires that the de been signed by the 6 should be detached 1	d by Pr	Part II. Other signif	icant conditions	ontributing to de	ath but not re	sulting in	the underlyi	ng cause	given in Part I.					o the cause of death? robably 4 🙀Unknown
Rec	The lay ate has page 2	Completed										24a. Wa auto per 1 Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of 2 2 No
Vital	ilcian: Th certificate rector, pag	Be (25. Was case reference examiner?	red to medical							of Death (Check only	one)		
o V	S O T	70	1 ☐ Yes 2 🛣	No	Hospital: 1 Kr	npatient 2	EP VOut	patient 3	DOA		rsing Home	5 🗆 Res	idence	6 ☐Other (Spe	icify)
\subseteq	the r	Certification:	27. Manner of Death 1 SNatural 2 □ Accident	h 5 Pending investigatio 6 Could not b	n	of Injury h, Day Year)		ury M		njury at Work? 1 Pes 2 1	No			ry occurred	
Divi	tel or At s after d al Direct ed in by	Certifi	3 Suicide 4 Homicide	determined	286. Pace	of Injury - At I	nome, fari ify)	n, street, fa	ctory, off	ice	281	. Location City or To			ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical (Check only one)	1 Medical Exam	nysician: To the niner: On the ba and mann	sis of examin	wiedge, ation and	daam oocui or investiga	red at the	e time, data an ny opinion, dear	d place and th occurred	due to the at the time	causa(s , date an) and marrier a d place, and du	s stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature and	title of certifier		***			29c. Lic	cense number			29d. Da	ite signed (Mon.	th, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

Reg. No.

2004

4c. County of Death

3. Time of Death

Birthplace (State or Foreign Country)

03 PM

2. Date of Death

Registrar DHMH 17 Rev 1/2001

State

Carolyn

31. Date filed (Month, Day, Year) APR 0 7 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wang

00

K.

RES-000

Sinai Hospital of Baltimore

			For State Registrar	State of	Marylan		artmen ertificat		lealth and I Death	Mental Hy	giene () Reg. No.	06	10907
	Physici	an	1. Decedent's Name (First, Middle, Last Margaret L. Mul							2. Date of De	5 ^{Day} 200	6 ^{Year}	3. Time of Death 8:35 A.M
C ×	/Medic		4a. Facility Name (If not institution, give		nber)		4b. City,	Town, or	Location of Death		4c. Count		
			Gilchrist Hosp					owso		1	Balt		
	Funeral Director		5. Social Security Number 6. Še 214-22-1018	x □M 2√xF	7. Age (In yrs. 90		Months		If Under 24 Hrs. Hours Min.	8. Date of Bid (Month, Da	th ly, Year) 1, 1915	Cou	place (State or Foreign ntry) ginia
			Usual Residence of Decedent				<u> </u>			oury 5	., 1,13		10d. Inside City Limits
	rs after death with the Marylan I, or itema 23a or 28a-f show Naminer must be notified at	ō	10a. State 10b. County			y, Town or L							1 ☐ Yes 2 ☑ No
	r 28a-i	rect	Maryland Howard 10e. Street and Number		E.	llicot	10f. Zip				10g. Citizen of	What Cou	ntry?
1	23a o	ai D	8720 Ridge Road #	216				210			USA		
+	er dea itema	uner	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Dece Armed For 1 Tes		.S. 13	Was Deced If Yes, spec	dent of H cify Cuba	ispanic Origin? (S ın, Mexican, Puert	pecify Yes or No o Rican, etc.)	Bfa	ck, White,	
9036	hours after death with the Maryland tural', or items 23s or 28ss-f show al Examinar must be notitled at	by F	3 Widowed 4 Divorced	If Yes, Giv Year or Da	е		1 🗆 Yes	2 🔀 No	Specify:		Speci	y. Whi	te
2 0 -5	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)		16a. Dec	edent's Usua e kind of wo	al Occup	ation during most of wor	king	16b. Kind of E	lusiness/Ir	ndustry
2.4	filed within 72 Hygiene. other than "na ent, tre Medic	dmo	Elementary/Secondary (0-12)	Coflege (1	-4or 5+)		rviso		")		Bankin	ıg	
25	a = 0 \$	Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)						18. Mother's Nar	ne (First, Middle	, Maiden Suma	те)	
\$ 2 <u>a</u>	should by	2	Phillip Wilson	and the second		405 14-1		(0)	Margare and Number or Ru	t Rodin	niser	Ctata 7i	a Codol
Z Z	12 s h an 7 to		19a. Informant's Name/Relationship (7 Anita M. Himmel		ughter		-		ls Road;				
G. C.	es 1 and 3 of Health filem 27 ir other tra		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. P	Place of Disp cemetery, cri	osition (Nar	ne of		Date	20c. Location		
i	Pages tment of tant: If it jury or o		4 ☐ Donation 5 ☐ Other (Specify)		w Catl					Baltim		
Pa∯	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service Lights	500	1142	90)	22. Name ar Funer	nd Addres <u>a</u> l H	ome of C	erling . atonsvi	Ashton S lle,Inc	chwa	b Witzke MD 21228
2	_		23a. Part1. Enter the disease, or comp shock, or head failure. List only of	fications that c	aused the deat	h. Do not e	1630 nter the mod	Edmo te of dyin	ndson Av ig, such as cardiac	or respiratory a	rrest,	Te,	Approximate Interval Between
	Physician		Immediate Cause (Finaf disease or condition	3	AC	wf.	e s	+	oke				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):							1100
(%		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cunsuq	uanca of):		-					
8359	te be executed ysician and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dunte	or as a conseq							_	
99	be ex sician (burial	icai E	issuming in occur, and	J 01 BUC	or as a conseq	uence or).							
687	# >£			0.						-			
2 × ×	Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	f death 3	□Ectopic p		,			ate of delive	very Day Year
500	t the de by the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregn 9□Unkno	ant at time of d	leath 5	Other (sp	oecity)					
S. P.	es that tigned by	by Pt	Part fl. Other significant conditions of	ontributing to de	eath but not res	ufting in the	underlying o	ause giv	en in Part I.		<u> </u>		the cause of death?
ord	w require been si should I		typertensi	on, c	avon	any	mrte	y c	() () ()		Yes 2 No	3 Pro	
Rec	The law ate has b	Completed					-				psy orm p d?	prior to co death?	opsy findings available ompletion of cause of
Ta Ta	an: Th tificate tor, pag	4	25. Was case referred to medical			-			26. Place of De	1 ☐ Yes ath (Check only		1 🗆 Yes	2 No
> >	Physicia this cert	To B	I Tes 25 No			ER/Outpati			4 🗀 Nursing r	_	idence 6 X		istogice
o uo	ding P h. After t funera	tion:	27. Manner of Death Natural 5 Pending Accident investigation		of fnjury th, Day Year)	28b. Time Injury	of M	28c. Injur Wor 1 □	yat k? Yes 2 ⊡No	28d. Describe	how infury occu	rred	
) Ivision of Vital Record	Attending or death. ector; After by the fune	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Pface	of Injury - At h	ome, farm, s					(Street and Num	ber or Ru	ral Route Number,
Wo.	Hospitei or 24 hours afte Funerai Dir tely filled in												
60	To the Hospitei or Ati within 24 hours after of To the Funeral Direct completely filled in by	dical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	iner: On the ba									
	To the Hos within 24 h To the Fur completely	Ne Ne	29b. Signature and title of certifier	1	87		29	c. Licens	e number		29d. Date sign	ed (Month	, Day, Year)
	1		Ill Anthor	my 1	ly	, cu	0	1)2	2065		Hord	, 5,	2006
	X	1	30. Name and address of person who	completed caus	se of de ter	п 23a) (Турі 6 70	e, Print)	Ch	arles S	t. Bu	lt. n	14	2006
	Sta		31. Date filed (Month, Day, Year)	32 ₂ A	legistrar's Signa								
	Registi	ar	APR 0 7 2006	Range	co . At	Man	16.7						

			1- stanend Item#8	per Ftate854V per FH 685	4747	t/ Pep /06⊘e	artment of F Ftificate of	lealth and N <i>Death</i>	Mental Hygid Reg	ene 0 0 6	10900
	Physic /Med	cal	1. Decedent's Name (First, Middle,	Odd			1		2. Date of Death Month	18/200	1958
	Exami Funeral Director		4a. Facility Name (If not institution, UNIVERSITY of W) 5. Social Security Number 215-98-3879	aryland med			\$ Baltin	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	4c. County of De	ath irthplace (State or Foreign Country)
	D .		Usual Residence of Decedent			-			07-20-	-1426	MS
	daryla f ehov	ō	10a. State 10b. County			Town or L					10d. Inside City Limits
	r 28a-	irect	10e. Street and Number		Ват	timor	e 10f. Zip Code		100	. Citizen of What 0	1) Yes 2 No
	ath witi	aiD	633 North Aisc	uith St.,	Apt 2A		21205			USA	·
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menial Hygiene. I Health and Menial Hygiene item 27 is marked other than "natural", or Items 23e or 28e-1 ehow other traumatic event, the Medical Examinational termitied at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 32 Widowed 4 Divorced	12. Was Decedent Armed Forces	Ever in U.S.	. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)	14. Race - Arr Black, Wh	ite, etc.
15-0	"natu	eted	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occupa	durina most of work	ina 16	ib. Kind of Busines	s/Industry
121	within iene. Than	Completed by	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NDT use retired YSitting	1)		01 : 1 1 0	
pu	be filled tal Hyg d other	Be C	17. Father's Name (First, Middle, L.	est)			ysiccing	18. Mother's Name	e (First, Middle, Ma	Child Ca:	re
ylaı	2 should be filed with and Mental Hygiene. Is marked other that aumatic event, the M	To	Prince Fleming					Mary Sl			
Maryland	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationshi						al Route Number, C		
	s 1 and 2 Health item 27 other tra		Barbara Dougla 20a. Method of Disposition		20b. Pład	Bugs on Dispo	helper Co sition (Name of matory or other plac	de Street	t. Edvewo	od MI) 2 c. Location - City o	21040
ë E	Page nent o ant: If ary or		1 ☑ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe				matory or other plac ews Cemet		01/2006		
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Li	. Elliber	res	5.5 5.5	Name and Addres	ss of Facility Met Street, A	ropolita: lexandria	n Funeral a, Va 223	Service In
			23a. Part Enter the disease, or consheek, or heart failure. List or	mplications that caused by one cause on each ti	the death.	Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arrest	,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_aSE	PSI	5					Onset and Death
	Examiner			Due to (or as	a consequer √AL		AILURE				
1	D iii	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	ice oil.					
<i>y</i>	and and al-trans	Examiner	that initiated events resulting in death) Last	c. VEN Due to (or as	T I LA	to R	DEPEN	DENI			
09289	tificate be executed g physician and as the burial-transit	edical E			PERT		imi				
	The law requires that the death certify alle has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ PNo 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)	* * *		23d. Date of de Month	livery Day Year
rds, P	quires that n signed b	by	Part II. Other significant conditions DEDENTIA		ut not resultir	ng in the ur	iderlying cause give	n in Part I.	23e. Did tobac	1	the cause of death?
Vital Records,	The law requir ate has been si page 2 should	Completed	RECENT INTE	STINAL (LESEC	Tion	J		24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
		BeC	25. Was case referred to medical examiner?					26. Place of Death	(Check only one)	No 1□Yes	2 No
o	Physion this on all dire	2	1 Yes 2 No 27. Marver of Death	Hospital: 1 Inpatie				r. 4 🗆 Nursing Hon	ne 5 🗆 Residence	6 ⊡Other (Spe	cify)
on	ttending Physician: Beath. tor: After this certific the funeral director,	tlon	1 Natural 5 Pending 2 Accident investigat	28a. Date of Injur (Month, Day	Year) 28	b. Time of Injury	28c. Injury Work' M 1 □ Y	at 2 ? ′es 2 ⊡No	8d. Describe how it	njury occurred	
Division	al or Attens s after death if Director: of in by the	Certification:	3 Suicide 6 Could not determine	be One Diese of lei-	iry - At home :. (Specify)	, farm, stre			8f. Location (Street City or Town, St	t and Number or Ru tate)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edicai	29a. Certifying (Check only one)	Physician: To the best of iminer: On the basis of and manner sta	exammation	dge, death and/or inv	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within: To the comple	Σ	29b. Signature and title of certifier	PRIMART				3948		Date signed (Monti	2) 2006
	7		30. Name and address of person who says the says	O completed cause of de	300	a) (Type, F	Print) L7 PLACE	SULTE	3H BALT	MORE M	10 21201
	Sta Registra	té ar	31. Date filed (Month, Day, Year) 2	006 Registra	r's Signature	Agree					

Angela M. Powell 06-2138 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

71		_	
State of Maryland / Department of Health and Mental H	lygiene	006	
Certificate of Death	Reg No.	UUU	1

State of Maryland / Department of Health and Mental Hygiene	nanc
Certificate of Death Reg. No.	.000.

			1 - State Registrar			Cei	rtificate	e of l	Death			Reg. No	o.	3 0	. 0000
	*		1. Decedent's Name (First, Middle,	Last)							2. Date of De			Vans	3. Time of Death
	Physici /Medio		Angela	Margaret :	Powe11						March	27 , °°	2006	5	4:42 P M
>	Examir		4a. Facility Name (If not institution,				4b. City,	Town, or	Location	of Death		40	. County	of Death	
			Calvert Memoria	al Hospita	.1		Pr	ince	Free	derio	k		Ca	alvert	t
	Funeral		5. Social Security Number		. Age (In yrs.	last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir	th Vear	1	9. Birthp	lace (State or Foreign
	Director		176-16-6857	1 □ M 2 🖾 F	90	Yrs.	Months	Days	Hours	Mili.	8. Date of Bir (Month, Da May 28	, 19	915	COUNT	PA
	<u> </u>		Usual Residence of Decedent												
	rylar how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							11	0d. Inside City Limits
	Ma Ma	cto	MD Calve	rt	Lu	sby									1 ☐ Yes 2 🖾 No
	라 58 1 28	Director	10e. Street and Number				10f. Zip	Code	-			10g. Ci	itizen of	What Coun	ntry?
	23a c		13-123 Harbor I	Lane			20	657				ī	JSA		
	dea	Funeral	11. Maritat Status	12. Was Deced Armed Ford		.S. 13.	Was Deced	ent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Rac	ce - Americ	
Maryland 21215-0036	be filed within 72 hours efter death with the Maryland tal Hygiene d other then "naturel", or Items 23s or 28s-f show event, the Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced		K No		1 ☐ Yes				riloan, etc./			y: Whi	
Ą	2 ho	Completed	15. Decedent's	s Education		16a. Deced	dent's Usua	I Occupa	ation			16b. H	Cind of B	usiness/Ind	dustry
15	ni de de de de de de de de de de de de de	pe	(Specify only highest Elementary/Secondary (0-12)	1	lor E. \	(Give	kind of wor DO NOT us	rk done d se retired	during mos	t of worki	n <i>g</i>				
2	iene iene	E	1.2	College (1-4	101 5+)	US De Agric			of			Gov	vern	ment	
ס	Hygie other t	Bec	17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Name	(First, Middle	, Maider	n <i>Sum</i> an	n <i>e)</i>	
<u>a</u>		To B	Gregory Baber						Joha	anna	Puntar				
2	d 2 should I th and Men t7 Is marke- traumatic	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Numb	er, City	or Town,	State, Zip	Code)
Ξ	2 6 7 2		Linda J. Casale,	/Niece		360 R	iver	Road	I. Nu	tlev.	NJ O	7110)		
Baitimore,	ーゴるち		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of			ate	20c. L	ocation ·	- City or To	wn, State
9			1 StBurial 2 ☐ Cremation 3 4 ☐ Conation 5 ☐ Other (Sp.		ate	emetery, cren				1/ AS	3-2006	For	coat	City	TD A
₫	artan ortan		21. Signature of Funeral Service Li		31	. JUSE	Name an	d Addres	s of Facilit	v Tor	es-Bre			City.	
n	permit. Peg Department Important: It eny injury o		1 Daniel	15/1/							rest C				
			23a. Part1. Enter the disease, or o	complications that cau	ised the deat										Approximate
			shock, or heart failure. List o Immediate Cause (Finat	nly one cause on eac	ch line.			,							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Mult	riple		rive:)							
	Examiner			Due to (or	as à conseq	uence ou									
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a conseq	uence of):									
/	ted nsit	Examiner	Cause (Disease or injury	1		,									
_	xecu and al-tra	xar	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):									
3	be e sicier buria														
68/60 ,	certificate be executed nding physicien and use as the burial-transit	ı∕Medical		a											
ž		/M	IF FEMALE:	23c. If yes, outco	me of pregna	ancy							23d Da	te of delive	nrv
n			23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 ∐ Feta ntattime of d	ldeath 3□	Ectopic pro								Day Year
j	the d y the ched	Physicia	1 □ Yes 2 风 No 9 □ Unknown	9□ Unknow			3 0 11.01 (45.	,							
7	thet led b deta		Part II. Other significant condition	s contributing to dea	th but not res	ulting in the ur	nderlying ca	ause give	en in Part I.		23e. Did t	obacco	use cont	ribute to th	e cause of death?
ras,	w requires that the death been signed by the ette should be detached for	ed by			_						10	Yes 2	No	3 🗌 Prob	ably 4 Unknown
ecord	law re as bee	Completed									24a. Was		24b.	Were autor	psy findings available
r	0 - 0	E										rmed?		death?	mpletion of cause of
	iiclen: Th certificate rector, pag	a l	25. Was case referred to medical						26 Place	of Death	1 Yes	2□No)	1 X Yes	2□ No
>		To B	examiner? 1 XX es 2 ☐ No	Hospital:	patient 2	ER/Outpatien	t 3(2)(0)D	A Othe			ne 5□Resi		6 □Oth	er (Specifi	<i>(</i>)
			27. Manner of Death	28a. Date of		28b. Time of	E-E-E-X	8c. Injury Work			28d. Describe				1 0
0	nding F tth. : After e funer	읉	1 □Naturat 5 □ Pending 2 ☑-Accident investiga	10	-O6	Injury	M		res 2	No F	Dasseng	Ser.	of c	dus	INVOIVED
DIVISION	Attending in death. ector: After by the fune	Ę.	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	Injury - At he	ome, farm, str		, office			28f. Location (Street ar	nd Numb	ner or Rura	l Route Number.
5	s afte	Certification;	- C TOTHICIDE	building	, etc. (Specif	Major	z rai	ad			ينواي الم	المحادثاً (ilRoi	ed and	BesteloBlu
	Hospitel 24 hours at Funerel D letely filled i		29a. Certifier 1 Certifying	Physician: To the b	est of my kno	wledge death	occurred a	at the tim	e, date an	d place, a	and due to the	cause(s	i) and ma	nner as st	ated.
	To the Hospitel or Attendl within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only	xaminer: On the bas and manne	is of examina r stated.	tion and/or inv	restigation,	in my op	oinion, dea	th occurr	ed at the time,	date an	a place,	and due to	tne cause(s)
	To t To t	Σ	29b. Signature and title of certifier		0	\	29c		number					d (Month, L	
}			effet (In	conin-	tall	Shan			O.C.M	1.E.		Mar	ch 2	28, 20)06
	1		30_Name and address of person w	ho completed cause	of death (Iten	n 23a) (Type.	Print)								

State Registrar

APR 0 7 2006

Patricia Aonica - Political III Penn Street, Baltimore, Maryland 21201
31. Date filed (Month, Day, Year)

APR 0 7 2006

APR 0 7 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** WESLEY REESEY APRIL 2006 3:00 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOSPITAL OF BALTIMORE SIANI BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10-04-1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XX M 2 F Months Days Hours Min. MARYLAND 212-30-1653 72 Yrs. Director Usual Residence of Decedent death with the Maryland 10a State 10c. City. Town or Location 10h County 10d. Inside City Limits Item 27 is marked other than "naturel", or Iteme 23s or 28e-1 ehow other traumatic event, the Madical Examinar must be notilled at MD. BALTIMORE PARKVILLE 1 Yes XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3120 DUBOIS **AVENUE** 21234 U. S. A. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Item 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) IRRIGATION COMPANY College (1-4or 5+) OWNER ÝEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be KENNETH REESEY IRENE SANTMEYER ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETTY M. REESEY (WIFE) 3120 DUBOIS AVENUE, PARKVILLE, MARYLAND, 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removat from State ö 04-10-2006 TOWSON, MARYLAND, 21204 permit. Page Depertment of Important: If eny Injury or once. HILLTOP SERVICE CORP. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 (R. G. RUTH) R. H. Butt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MYOCAKDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISPASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or): Examiner HYPERLIPIDEMIA burial-tran law requires that the death certificate be execut resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the burial Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 4907 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 1 ☐ Yes 2 A No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: After this certific funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one| Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 POA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funeral C completely filled i 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Greck only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Levens Q. holad rus APRIL 4, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKVILLE MO NOLAW MO R. 8831 SATYR HILL RD SERENA 3. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 7 2006 Registrar

Baltimore, Maryland 21215-0036

Physiciai /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mardical Examiner must be rightlifted at once.

Physician /Medical Examiner

		Please	Type or Prin					-			ble.	10011
	1 - For State Registrar		State of Ma	•	epartme C <i>ertifica</i>			Mental H	ygiene Reg. No	Sugar Sugar	6	9
_	1. Decedent's Name	(First, Middle, La	st)					2. Date of I	Death Da	ay .	Year	3. Time of Death
n al			. Rudy	/				April		2006		1:25A [™]
r			e street and number)		4b. Ci		Location of De	ath	40		of Death	
ı	Stella 5. Social Security No	Maris Ho		e (In yrs. last birth	rday) If Un	Timor der 1 Year	If Under 24 H	rs. 8. Date of E	Birth	Bal	timo 9 Birth	re place (State or Foreign
	219-46-29 Usual Residence of	948	X M 2□F		Month		Hours Mi	June	Dav. Year	46	Cou	ryland
	10a. State	10b. County		10c. City, Town	or Location							10d. Inside City Limits
ctor	Maryland	Baltimo	re	Balt	imore							1 ☐ Yes 2 No
<u>Jre</u>	10e. Street and Nun	nber			10f.	Zip Code			10g. C	itizen of \	What Cou	ntry?
al	10 Carri	iage Walk	Court			21234				U.S.		
rue	11. Marital Status		12. Was Decedent Armed Forces?		13. Was De If Yes, s	cedent of H specify Cuba	ispanic Origin? .n, Mexican, Pu	(Specify Yes or I erto Rican, etc.)	No-		e - Ameri k, White	can Indian, , etc.
Be Completed by Funeral Director	1 Never Marrie		1	969-1971		s 2 🗘 No	Specify:			Specify	Wh	ite
ete	(Speci	 Decedent's Entry only highest gra 		(Decedent's U Give kind of life. DO NO	work done	during most of w	vorking	16b. F	Kind of B	usiness/Ir	ndustry
ф	Elementary/Secon	ndary (0-12)	College (1-4or 5	5+)	Appra		,		Re	al F	stat	e
ပို	17. Father's Name (First, Middle, Last,			пррг	41301	18. Mother's N	lame (First, Midd				
ToB	Emory	Emanu			Mailian Addr	ana (Streat	Marga	ret Rural Route Num	Pear			ifler
	19a. Informant's Na					2.5			-			
	Marriett 20a. Method of Disp	t H. Rudy	Wife					ırt Bali				Own, State
	1) Burial 2	Cremation 3	Removal from State	20b. Place of I cemetery			1				•	
	4 Donation	5 Other (Specif	y)	Boonsbo				-2006		nsbo		Maryland
	21. SQL TIPE 1	neranservice Licer	1500				ss of Facility					Home, Inc.
-	23a Part 1 Enter th	e disease or com	plications that caused	the death. Do no			Road	Towsor		ryia	nu Z	1204 Approximate
	shock, or hear Immediate Cause (t failure. List dnly	one cause on each li	ne.		,	3,					Interval Between Onset and Death
	disease or condition resulting in death)	-	mELAN		ν.							
			Due to (or as	a consequence of).							
e	Sequentially list con if any, leading to im	mediate B	b. Due to (or as	a consequence of):							
miner	Cause (Disease or ithat initiated events	njury										
Exa	resulting in death) L		Due to (or as	a consequence of):		_					
cal			d									
ed												
20/2	IF FEMALE: 23b. Was decedent		23c. If yes, outcome	of pregnancy 2 Petal death	3∏Ectonic	c pregnancy					e of deliv	,
SICIE	in the past 12 i		4☐Pregnant at		5 Other					Mo	nth	Day Year
žu.	9 Unknown											
ed by	Part II. Other signifi	cant conditions of	ontributing to death b	ut not resulting in t	the underlyin	ig cause giv	en in Part I.	1	tobacco Yes 2			the cause of death? bably 4 XUnknown
Completed by Physician/Medical Exa								per	topsy rformed?		Were autorior to codeath?	opsy findings available ompletion of cause of
Z e C	25. Was case referr	ed to medical					26. Place of D	1 ☐ Yes leath <i>Check on</i>			_ 162	2 U NU
	examiner? 1 ☐ Yes 2 😿 I	No	Hospital: 1 ☐ Inpatie	ent 2 ER/Outp	atient 3	DOA Oth				6 ▼]Oth	er (Speci	by HOSPICE
	27. Manner of Death	1	28a. Date of Inju (Month, Da			28c. Injun Wor		28d. Describ				
atlo	1 XNatural 2 ☐ Accident	5 Pending investigation	n	,	M		Yes 2 □ No					
Medical Certification; To	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		ury - At home, farr c. (Specify)	n, street, fac	tory, office			(Street a		er or Rur	al Route Number,
Ç												
cai			nysician: To the best miner: On the basis of	examination and								
Ö	one)		and manner sta	ated.					29d. Da			

12

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

> State Registrar

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) APR 0 7 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

2300 DULANEY VALLEY RD. . Registrar's Signature

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

			For	State of Maryl	and / Depa	artmer	nt of H	ealth an		-		agible.	10019
			1 - State Registrar		Ce	rtificat	e of L	Death	10.5	Reg	. No.	100	10316
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Marie Zelda Smi						A ^N	onth Pril	Дау,		3. Time of Death 10:10am
)	Examir	ıer	4a. Facility Name (If not institution, give s 2233 W. Saratog			1		Location of E	Death		4c. Co	unty of Death	N/A
			5. Social Security Number 6. Sex		rs. last birthday)		ltim	If Under 24	Hrs. 8. D	ate of Birth			place (State or Foreign
	Funeral Director			M 2√F 97	Yrs.	Months	Days	Hours	Min. Ma	ate of Birth Month, Day, Y	,190)8 Cour	MD MD
	Maryland a-f ehow	tor	10a. State MD 10b. County	N/A 10c.	City, Town or Lo	ocation Limoi	ce					1	0d. Inside City Limits 1 AYes 2 No
	sth with the Marylan 23a or 28a-f ehow	Funeral Director	10e. Street and Number 2233 W. Saratog	a Street		10f. Zip		1223		10g	. Citizen	of What Cour	usa
920	or items	þ	11. Marital Status 1 Never Married 2 Married 3 XMidowed 4 Divorced	I2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	ŀ	Was Dece If Yes, spe 1 Yes		spanic Origin n, Mexican, P Specify:	? (Specify uerto Ricar	res or No- n, etc.)		Race - Americ Black, White, ecify: Bla	etc.
215-0	within 72 ho ene. then "natur he Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupa ork done o se retired,	ition luring most of	working	16		of Business/Inc	ŕ
21	od with	S	5th			Domes	stic					Home	
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental aumatic event, the Mental aumatic event.	To Be	17. Father's Name (First, Middle, Last) Theodore Hollan	d				18. Mother's Magg		coss	iden Sur	name)	
Mary	s 1 and 2 should be filed within 72 hours if Heelth and Mental Hygiene. Item 27 is marked other then "naturei", other traumatic event, the Mudical Exp		19a. Informant's Name/Relationship (Type Cecile E. Pickf	ов, Print) ord	19b. Maili 1727	ng Address Wes	s (Street a	nd Number o n Run	Rd (te Number, C Cockey	ity or To	wn, State, Zip 11e M	D 21030
Baltimore,	Peges 1 a ent of Hei nt: If item ry or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)		b. Place of Dispo cernetery, crei				4 / 8 / ()6		on - City or To	
Balti	permit. Peges Depertment of important: If it any injury or o		21. Signature of Funeral Server Cense	98	2:	2. Name ar	nd Addres	s of Facility	Chatr	nan-Ha	arri	s Fun	eral Home
760,	Physician /Medical Examiner portion and portion in the price of the p	cal Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a control of the block) Due to (or as a control of the block) Due to (or as a control of the block)	vel Pres	sur	ov K); - 16	4				Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed site hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	⊒Ectopic pi □ Other (sp					23d.	Date of delive Month	ery Day Year
	ires that (signed by d be deta	1 by Ph	Part II. Other significant conditions con	tributing to death but not	resulting in the u	inderlying o	ause give	n in Part I.	2	23e. Did tobac	2 1 N		ne cause of death?
Division of Vital Records,	sician: The law requi certificete hes been irector, page 2 shoul	Completed by							-	24a. Whas an autopsy performe ☐ Yes 2 ☑	02/	prior to cor death?	psy findings available mpletion of cause of
ital		Bec	25. Was case referred to medical examiner?							ck only (ne)			
<u>~</u>	> 0 D	၉	1 ☐ Yes 2 ☐ No	ospital:				4 🗀 (4015)(-		Other (Specify	v)
ion	Attending F r death. ector: After by the funer	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o njury	M	28c. Injury Work 1 □ \	at ? ′es 2 □No	28d. t	Describe how	inju ry oc	curred	
Divis	ai or Atte s efter de s Directo ed in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	at home, farm, str ecify)	reet, factor	y, office			ocation (Streetity or Town, S		umber or Rura	l Route Number,
	To the Hospital or Attending Ph within 24 hours eiter death. To the Funerel Director: After thi completely filled in by the funeral	Medical (29a. Certifier 1 ☐ Certifying Physical (Check only one) 2 ☐ Medical Examin	ician: To the best of my ler: On the basis of examand manner stated.	knowledge, deat pination and/or in	h occurred ivestigation	at the tim	e, date and p inion, death o	lace, and d occurred at	ue to the caus the time, date	e(s) and	manner as st	ated. the cause(s)
	To the withing To the Comp	M	29b. Signature and title of certifier)			c. License					gned (Month,	
			Jun Il	ameni	0		020	2422		4/	-7	-06	
	6		30. Name and address of person who co.	nenici 17%	1tem 23a) (Type.	Print) Re	luve	el so	Bul	dmux	170	-06 1 2 11	0/
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 7 20	32. Registrar's Si	gnature.	met.	9						

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SHUFOR **Physician** 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8023 McDonough Road Pikesville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 211 F Director 017-22-1100 Yrs. Mar. 29, 1908 98 GA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is markad other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be multilled at tx Yes 2 □ No Director Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 8023 McDonough Road USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Developmental permit. Pages 1 and 2 should be tiled withir Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than any injury or other traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) Center 12 Nurses Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Isom Daniels 2 Hannah Reaves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Will Spencer, Jr./Nephew 1932 Red Clover Dr., Florissant, MO 20b. Place of Disposition (Name of cometery, crematory or other place)
Timothy
Plain Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denetion 5 Other (Specify) Apr.5,2006 Norton, MA 21. Signature Funeral Service Licens Dyer Lake Funeral 161 Common Wealth Home N. Attleboro, MA onnie 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician /Medical ASCULAR **Examiner** esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SCULAR DISEASE burial-transit and Box 68760, 99 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XNo 2 completely filled in by the tuneral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attanding 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 🗌 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical nd title of certifier 29b. Signature Completed cause of death (Item 23a) (Type, Print)
LAWOYIN M-D. 5310 OLD CTRD #305; RANDALLSTOWN, mD 2/133 DLUSEGUN 31. Date filed (Month, Day, Year) State Registrar

	1 - For State Registrar	State of Marylar	nd / Department of Heal Certificate of Dea		giene 0 6	10914
Physician /Medical Examiner	1. Decedent's Name (First, Middle Company)	Harry	Schmidt 4b. City, Town, or Loca	2. Date of De Month	Day 2006 4c. County of Death	3. Time of Death
Funeral Director	GILCHYIST 5. Social Security Number 21840-2314	6. Sex/ 1 M 2 F	last birthday) If Under 1 Year If U	inder 24 Hrs. 8. Date of Bit wurs Min. (Month, Da	Balt	More place (State or Foreign place) prepared
in the Maryland or 28s-f show as notified at	Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number	rford 5	ty, Town or Location	,1	10g. Citizen of What Cour	1 General Property 1 Od. Inside City Limits 1 General Property?
ltama 23a	3 ☐ Widowed 4 ☐ Divorced	If Yes Give	If Yes, specify Cuban, Me	ic Origin? (Specify Yes or No exican, Puerto Rican, etc.)	14. Race - Americ Black, White,	can Indian, etc. Dife
Maryland 21215-0036 nd 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other in "natural", or traumatic avent, the Medical Extern To Be Completed by F	15. Deceder (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	most of working Body Mother's Name (First, Middle	16b. Kind of Business/In	dustry a Garage
Maryland Id 2 should be fil Ith and Mental H 27 is marked out		Schmic	19b. Mailing Address (Street and N	Margare	+ ZImm	nerman Code)
Baltimore, permit. Pages 1 ar permit. Pages 1 ar perment of Hee my mortant if itam 2 my portant if itam 2 arce.	20a. Method of Disposition 1 1 Disposition 1 Disposition 2 Donation 5 Other (5	3 □Removal from State	Place of Disposition (Narde of cometery, crematory of other place) The Complex of Compl	Date 4/7/06 acility Evans Fur	20c. Location - City or To	own, State MI BELLIE
Physician	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	complications that caused the dea only one cause on each line.	th. Do not enter the mode of dying, such		prest Hill rest,	Approximate Interval Between Onset and Death 4 Lavs
3-06 0110 760, Its be executed in the be executed and burial-transit cal Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consect of the consec	quence of):			(curs
O. Box ne death cer the ettendir hed for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3 □Ectopic pregnancy		23d. Date of delive Month	ery Day Year
Records, P. (Records, P. (As law requires that the law requires that the law spend by age 2 should be delected by Phrompleted	Part II. Other significant condu	ons contributing to death but not re-	sulting in the underlying cause given in l	10	N	pably 4 Unknown
of Vital Record Physician: The law requir this certificate has been si ral director, page 2 should TO Be Completed	25. Was case referred to medica examiner?			24a. Was auto perfi 1 ☐ Yes Place of Death (Check only	ormed? death? 2 No 1 Yes	psy findings available mpletion of cause of 2 No
Z g and and lo	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendii 2 Accident investi 3 Suicide 6 Could 4 Homicide determ	28a. Date of Injury (Month, Day Year) gation not be	28b. Time of Injury at Work? M 28c. Injury at Work? 1 Yes	2 🗆 No	how injury occurred Street and Number or Rura	
ScHM is Division to the Hospital or Attend within 24 hours eller death To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier Check only 2 Medical one)	g Physician: To the best of my kn	owledge, death occurred at the time, da ation and/or investigation, in my opinion	ate and place, and due to the	cause(s) and manner as s	stated. o the cause(s)
To the within 2 To the comple	Ma	lins	29c. License num D 58 30	3	29d. Date signed (Month, April 3 20	Day, Year)
State	Amon CHMG	1 00 0 000		rampre mo	21204	
Registrar	APR 0	7 2006 32. Hagistrar's Sign	ORIGINAL			

	AME	ND	Unpend Item#23a,4 1- For ITEM#5 PERFH Registrar	State of Mary , G856, 6/1	706 W.S.	artment of H	lealth and Death			16	. 1915
	Physici	an	Decedent's Name (First, Middle, Last)		aller mo	N		2. Date of Deat Month	Day	Year	3. Time of Death
	/Medi		GEORGE		SHELTO			MARCH		006 y of Death	6:08 A M
	Examir	ner	4a. Facility Name (If not institution, give s		Tro	4b. City, Town, or CHEVERLY		n	PRINC		RGE'S
	Funeral		PRINCE GEORGES HO 5. Social Security Number 6. Sex		yrs. last birthday)	II Under 1 Year	If Under 24 Hrs	8. Date of Birth		9. Birthp	place (State or Foreign
	Director		219-48-6077	M 2□F 56	Yrs.	Months Days	Hours Min.	(Month, Day, APR. 29	1949	MARY	**
	D .		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ocation				1	Od. Inside City Limits
	faryla et et	ŏ	MD PRINCE GI		APITOL H						1 XYes 2 No
	28a-1	rect	10e. Street and Number	SORGE B	2111011	10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
	3a or	ā	13 CINDY LANE # 3	02		2074	3		U.S.A.		
	within 72 hours after death with the Maryland one. then "naturel", or iteme 23a or 28a-f ehow the Medical Exant or must be incitited at	Completed by Funeral Director	11. Marital Status	Was Decedent Ever Armed Forces?	r in U.S. 13.	Was Decedent of Hi Il Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-		ce - Americ	
9	or its	F	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:	,,	Speci	4	
21215-0036	hours turel',	q p	3 Widowed 4 Divorced	Year or Dates:	16a Daga	dent's Usual Occupa	ntion	1		DIT	ACK
7	in 72	siete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired	furing most of wo	rking	16b. Kind of E	302111622/111	dustry
212	r ther	E O	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	SHIP	PING & RE	CIEVING		PRIVA'	TE	
	e filed al Hygid other vent, I	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle, M	Maiden Suma	me)	
lai	ould be Mental larked o	To E	GEORGE R. SHELTON	SR.			DOROTHY	L. COOP	ER		
Maryland	S D F F		19a. Informant's Name/Relationship (Typ. JEWEL C. SHELTON/V			ng Address (Street a				-	20743
Baltimore,	of Her of Her if Item or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ro		Ob. Place of Dispo cemetery, crei	nsition (Name of matory or other place			20c. Location		
Ë	Pag tment tant: lury o		4 □ Donation 5 □ Other (Specify)			CTION CEM			LINTON		
Ball	permit. Pages 1 and 2 Department of Heelth a Important: if item 27 is any injury or other trac		21. Signature of Funeral Service License	/ //		2. Name and Addres 7474 LAND	250 15C 150 200	. B. JENK			. НОМЕ 20785
0,	Physician /Medical Examiner but stee paragraph of the parial-transit	dical Examiner	23a. Part 1. Enter the illease, or complice shock, or heart a liure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Atheroscler Due to (or as a co	rotic cardi			or respiratory and			Approximate Interval Between Onset and Death
Box 68760,	eath certif attending for use a	Physician/Medica	in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy				ate of delive	ery Day Year
P.O.	that the d ed by the detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	7 01 00 011	The second of th					
	s that ned b s deta	by Pi	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use cor	ntribute to th	ne cause of death?
rds	w requires been signs should be	ed t						1 □ Ye	s 2 No	3 🗌 Prob	ably 4 🛣 Unknown
al Records,		Completed						24a. Was a autops perform 1X Yes 2	V	Were auto prior to co death? 1 🛣 Yes	psy lindings available repletion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	25	ath (Check only on			
of	ting After Iune	tion: To	1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	28c. Injury Work	4 □ Nursing F	lome 5 Reside 28d. Describe ho			γ)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attercompletely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S		reet, lactory, office		28l. Location (St. City or Town		ber or Rura	I Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (ician: To the best of mer: On the basis of exa and manner stated.							
	To the within 2 To the comple	Me	29b. Signature and title of certifier	, 11	,	29c. License	number	2	9d. Date sign	ed (Month,	Day, Year)
)			· Yn	M. It	- ta	0.0	.M.E		4-	/ -	06
			30. Name and address of per an who con			Print) PENN STRE	ር ጥ ይ ለተጥተ	MODE MAI	OVT AND	2120	11
_			A. RUBION	VIII).	111	CENN SIKE	PI DWPIT	EIONE, FIAI	TIMND	2120) T

Registrar
DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	and / Depa		ealth and M	lental Hy	giene Reg. No. 006	10915
	Physici	an	Decedent's Name (First, Middle			~ 77		2. Date of De.	Day Year	3. Time of Death
	/Medi	cal	John	Louis		Sullivan		April	5, 2006	8:12 P M
	Examir	ier	4a. Facility Name (If not institution, 3408 Northway			4b. City, Town, or			4c. County of De	ath
	Funeral				rs. last birthday)	If Under 1 Year	imore	8 Date of Bird	th 9 Bi	rthplace (State or Foreign
	Director		212-34-5652	104 105	8 Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da Jan. 1	y, Year) 1,1938 Mar	ountry)
	D ,		Usual Residence of Decedent					oun.	1,1330	7
	laryfa shov	5	10a. State 10b. County		city, Town or Lo					10d. Inside City Limits
	the N	ect	10e. Street and Number		a t t t i i i o					Yes 2□No
	72 hours after death with the Maryland natural', or itams 23a or 28a-1 show Jical Exiz. ilref must be natified at	Funeral Director	3408 Northw	av Drivo		10f. Zip Code			10g. Citizen of What C	ountry?
	death ms 2;	lera	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	21234 Was Decedent of His		ecify Yes or No-	USA - 14. Race - Am	erican Indian
9	or its	Ţ	1 Never Married 2 Marrie			Was Decedent of His If Yes, specify Cubar		Rican, etc.)		ite, etc
93	72 hours natural', nicel ext	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: U	UHITE
21215-0036	"natu	Completed	15. Decedent' (Specify only highes		16a. Dece (Give	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of work	ing	16b. Kind of Business	s/Industry
12	d within giene. ir than "	g m	Elementary/Secondary (0-12)	College (1-4or 5+)	1	vern own			Belhaven	Tavern
0	filed Hygi thar		17. Father's Name (First, Middle, L	ast)	14			e (First, Middle.	Maiden Sumame)	
lan	should be nd Mental marked o	To Be	James Sulliva	an				, , , ,	,	
Maryland	s 1 and 2 should f Health and Men itam 27 is marke othar traumatic	_	19a. Informant's Name/Relationsh	ip (Type, Print)daughte	er 19b. Mailir	ng Address (Street a	nd Number or Rura	ret Pf	er, City or Town, State,	Zip Code)
	1 and 2 Health am 27 i		Lisa M. Brozr						Maryland	
ore	Pages 1 nent of He int: If itan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		o. Place of Dispo	sition (Name of matory or other place		Date	20c. Location - City o	r Town, State
Ë	Pag Iment tant: jury c		`4 ☐ Donation 5 ☐ Other (Sp	ecify) S		heart Je			altimore	
Baltimore,	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service-L	icensee	- ²² 2	Name and Address OSEPH N. 63 S. CO	s of Facility Zannin	o Jr.H	Funeral H altimore,	ome Md.21224
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused the de	eath. Do not ent	er the mode of dying	, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· (Dugg	Aur.	Host =	tailur	4		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	1	0 - 6			
	x	_	Sequentially list conditions,	b. Carona	my H	ttans o	71869			
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a corrs		, ,				
,	cate be executed physician and the burial-transit	xai	that initiated events resulting in death) Last	c. Due to (or asca cons	equence of):					
8760,	icate be ex physician s the buria		l l	d						
9	tiflicating phy as th	ledical								
Вох	The law requires that the death certific tie has been signed by the attending pl bage 2 should be detached for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		Ectopic pregnancy			23d. Date of de	livery
о. П	e dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time o		Other (specify)			Month	Day Year
Ρ.	that the de ned by the detached		9 ☐ Unknown Part II. Other significant condition		roculting in the		- AP1	70- Dida-		44.00
ds,	signe d be o	d by	He 20 Haron	Q XODOM	A M	Calloring cause giver	1 2012	239. Did to	es 2□No 3□P	robably 4 Unknown
Sor	w requir been si should	etec	A CIT CIT	1/2	2-14	-chaj v	/	7		
Vital Records,	hysician: The law his certilicate has t I director, page 2 s	Completed	Man Tun	19118 /11/10	muy			24a. Was a autop: perfor	sy prior to	utopsy findings available completion of cause of
a		e Co	25. Was case referred to medical					1 Yes	2 1 Ne	3 2 □ No
	ysicis s cert direct	ToB	examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatien	Othor	26. Place of Death		ence 6 Other (Spe	neifel
0	- E		27. Manny of Death	28a. Date of Injury	28b. Time of	28c. Injury a			ow injury occurred	icity)
Division of	Attending Physician: It death. actor: After this certific: by the funeral director.	Certification:	1 Vatural 5 Pending investiga	ition	Injury		es 2 □ No			
<u>\S</u>	l or Atte after de Diracto	titio	3 Suicide 6 Could no 4 Homicide determin		t home, farm, stre	eet, factory, office		28f. Location (S City or Town	treet and Number or R	ural Route Number,
	ital o	Se								
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 D Certifying (Check only one) 2 Medical E	Physician: To the best of my k	nowledge, death ination and/or inv	occurred at the time estigation, in my opin	, date and place, a nion, death occurre	and due to the c ed at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	o tha ithin (o tha omple	Med	29b. Signature and title of certifier.	ald manner stated.		29c. License			29d. Date signed (Mon	
)	٤٦٤⊣		1	MM un I		Du	2908		411 1	24,7,704.7
	,	-	30. Name and address of person,w	ho completed cause of Heath (II	tem 23a) (Type 1	Print)	0100	,	110/0	
	Q		808 5- Cont	Lina St. 1	30/h	ner '	WD	212	24 DA	UIP SCHARPF KID
	Sta		31. Date filed (Month, Day, Year)	32. Redistrar's Sig	nature	1	<i>V</i>			, , ,
	Registra	ar	APR 0 7	2006	N A	DE LES				
DH	MH 17 Rev 1/20	001			. 3					

			1 - For State Registrar	State o	f Maryla		artment of rtificate of		and Mental		ne) (16	10917
			1. Decedent's Name (First, Middle, La	ast)						of Death			3. Time of Death
	ysicia Jedic		Leslie R. Somers						Avu	1	Day	Year	8100 AM
	amin		4a. Facility Name (If not institution, given	ve street and nu	mber)		4b. City, Town,	or Location o			4c. County		0.001
6		•	Shady Grove Adve	ntist Ho	ospita:	1	Rockv	ille			Mont	gomei	v
Fun	eral			Sex	7. Age (In yr	s. last birthday)	If Under 1 Year			of Birth		9. Birthp	lace (State or Foreign
Direc			007-01-2078	1⊠M 2□F	89	Yrs.	Months Days	Hours	Min. (Mon. May	12	1916	Verm	try)
D D			Usual Residence of Decedent										
rylar	3		10a. State 10b. County		10c. (City, Town or Lo	cation					1	0d. Inside City Limits
M -	9	Ş	Virginia Orang	e		Locus	st Grove						1 ☐ Yes 2 🖾 No
5 th	2	ē	10e. Street and Number				10f. Zip Code			10g	. Citizen of	What Coun	try?
th wi	2	Funeral Director	717 Eastover Parl	kway			22508	8			Unite	d Sta	tes
dea	Ē	ner	11. Marital Status	12. Was Dece		U.S. 13.	Was Decedent of	Hispanic Orig	gin? (Specify Yes	or No-	14. Rac	e - Americ	an Indian,
or late	를	F	1 Never Married 2 Married	1 🗆 Yes	2 🔯 No				, Puerto Rican, et	C.)		ck, White,	etc.
003 eurs	2	þ	3 Widowed 4 Divorced	If Yes, Gir Year or D	ates:		I∐Yes 2⊠No	Specify:			Specif	Whi	te
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thypiene.	lica lica	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Deced	lent's Usual Occu	pation	t of working	16	b. Kind of B	usiness/inc	lustry
전 를 를 등	B B	힏	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work done OO NOT use retire		or woming	E	Bail B	earin	gs
S S S S S S S S S S S S S S S S S S S	3	ပ္ပ		1		Engir	eer Insp	pector		C	ompan	У	
T ed at the contract of the co	- N	Be	17. Father's Name (First, Middle, Last					18. Mothe	r's Name (First, M	liddle, Ma	iden Suman	ne)	
Y Man Signature	atic	၉	Bartholomew Some	rs				Via	letti Si	llie			
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental hygiene. T is marked other then "natural", or	בא בי	1	19a. Informant's Name/Relationship		_				or or Rural Route A				
and and ealth	1 2		Robert S. King /	Son-In-				Store I	Drive, G				land 20874
Baltimore, Maryland 21215-0036 semil. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. mportant: If liem 27 is marked other then "natural", or iteme 23s or 28s-1 show	5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from		Place of Dispo cemetery, cren	sition (Name of natory or other pla	ace) A	April 8,	200	c. Location -	City or To	wn, State
Pa Pa	ri ri		4 ☐ Donation 5 ☐ Other (Special				enter Ceme	tery	2006		arnet,		
Baltimor permit. Pages Department of I	DUC .		21. Signature of Funeral Service tice	nsee)		22	. Name and Addr	ess of Facility	Robert A	A. Pu	mphre	y Fun	eral Home/
W 40 E	ē 0	1	Let S		MC	1433 Ro	ckville,	Mary	300 West land 208	$\frac{10000}{10-28}$	tgome 05	ry Av	enue,
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cone cause on e	aused the de ach line.	ath. Do not ente	or the mode of dy	ing, such as o	cardiac or respirat	ory arrest			Approximate Interval Between
Physic	ian		Immediate Cause (Final disease or condition	Co	2 pu	lmone	le						Onset and Death
/Medi			resulting in death)	Due to	or as a conse	equence of):							1
Exami			Sequentially list conditions,	b. 10	thing								yeurs
/p :	_	ner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence or):							0
V age	trans	Examiner	that initiated events	c									
ien a			resulting in death) Last	Due to (or as a conse	equence of):							
8760, cate be executed ohysicien and	90	dical		_ d								_	
ing p		Sec	IF FEMALE:								1	1	
BOX 6	lor use	an	23b. Was decedent pregnant	23c. If yes, out 1□Live b	come of pregi		Ectopic pregnanc	ev				te of delive	•
the deal	0	20	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	4☐Pregn 9☐Unkno	ant at time of		Other (specify)	<u> </u>			Мо	nth	Day Year
The Love 168760, The law requires that the death certificate be executed that has been signed by the attending physician and many consistent and the consistent of the consist	erac	Physician/Me	9 🗆 Unknown										
igned I	9	۵	Part II. Other significant conditions of	contributing to de	ath but not re	sulting in the un	derlying cause gr	ven in Part I.	23е.	Did tobac	co use cont	ribute to the	e cause of death?
COLDS		ed ed	coso, prema	e effe	isor pa					Yes	2 🗆 No	3 🗍 Proba	ibly 4 ∐Unknown
Hecords, he law requires t e has been signe	, N	ed .								Was an autopsy	24b. \	Were autop	sy findings available
	Ž ,	Completed by							101	performed	1?	death?	2□ No
VITAL I			25. Was case referred to medical examiner?					26. Place	of Death Check of	Arrest State			
OT V Physic rthis or	5	2	1 ☐ Yes 2 No			☐ER/Outpatient	3□ DOA Ot	her: 4 Nur	rsing Home 5	Residence	e 6 □Oth	er (Specify)
On O ding Ph After th	2	ë	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at ork?	28d. Desc	ribe how i	njury occurr	ed	
VITENCIA Geath. ctor: A	9	cat	2 Accident investigation	n			M 1 []Yes 2 □ N	10				
UIVISION OT VITA for Attending Physician: after death. Director: Atter this certific	<u> </u>	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place	of Injury - At . ng, etc. (Spec	home, farm, stre	et, factory, office		28f. Locat City o	ion (Stree r Town, S	t and Numb tate)	er or Rural	Route Number,
urs al	20		<u> </u>	1						-			
UIVISION To the Hospital or Attention Within 24 hours after deat To the Hospital Director:		Medical	29a. Certifier 10 Certifying Ph (Check only one) 2 Medicar Exar	nmer: On the ba	isis of examir	nowledge, death nation and/or inv	occurred at the ti estigation, in my	ime, date and opinion, death	d place, and due to h occurred at the t	the cause ime, date	e(s) and ma and place, a	nner as sta and due to	ited. the cause(s)
To the Within 2 To the		ĕ -	29b. Signature appl title of certifie	and manr	er stated.		29c. Licens						
7 ≥ ₹ S	3		Al. IV	1/1/100	Var	des	100	>		1	Date signed		•
	,	1	11 was a	www		510	27	453		1/11	vut	1 1	06
18	ν		30. Name and address of person who			em 23a) (Type, F HAD Y	Print)	en	ROCKUR	16	No	210	Cī.
-	CASS		Aran CHANAUS M 31. Date filed (Month, Day, Year)	-	istrar's Sign		UTKUVR	res !		21	עוד	NO	3 0
Rec	Stat sistra	_		- 5	nonar a aigi	K L	1						
DHMH 17 Be			APR 0 7 2	UU6 JU	dus.	A James							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** 3, April 2006 1:35 pm JOYCE SHIRLEY MONTY SMITH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Pickersgill Towson Baltimore County If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2XXF 102-14-4245 87 Yrs. Director New York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2XXNo Director Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Ave. #426 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specity: þ Specify: white 3 ☐ Widowed 4 K Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Heath and Mental Hygiene. ant: If itam 27 is marked other than * Elementary/Secondary (0-12) College (1-4or 5+) elementary teacher education or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Stephen Monty Ruth Inez Gonga 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5425 Auburn Ave. Bradenton, FL 34207 Gerald P. Rogers - executor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 04/06/06 Balto. MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, MD 21212 Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, flock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the buria Completed by Physician/Medical the ass IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 10 Day Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sas autopsy perform. 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred : After t or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 1 30. Name and address of person completed cause of death (Item 23a) (Type, Print) 6201 6 Bine 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1tem 15 per in 834 4-7-06 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 1, 2006 Year **Physician** 12:46 PM Francis Anthony Stelmachowicz /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A 113 S. Collins Avenue Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 12/24/1932 Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Director 276-30-2301 73 Ohio Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Madical Examiner must be notified at 1 Nes 2 □ No Directo Maryland N/ARaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 113 S. Collins Avenue 21229 United States or itams 23a deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If itam 27 is marked other than "natural", or ital 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 2 3 Widowed 4 Divorced Year or Dates: 1955-59 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Salesman Home Improvement 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Anthony Stelmachowicz Grace Mildred Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kapur / Daughter 5724 Artesian Drive Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages the Department of Humortant: If its any injury or ot once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04/11/2006 Owings Mills, Maryland Garrison Forest Vet. 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Ligenses 5311 Edmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial **Physician** mmediate /Medical resulting in death) Due to (or as a consequence of) Examiner Atherocclerosis oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ hyperlipidenia should be Completed 1 Yes 2 No 3 Probably 4 Unknown been s diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy certificate 1 Yes 2 No or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident illed in by the 6 Could not be 3 ☐ Sutcide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 St Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0035363 rson who completed cause of death (Item 23a) (Type, Print) 10 N. Greene St. Baltimore, MD 21201

DHMH 17 Rev 1/2001

State

Registrar

Sandra Marshall

7 2006

31. Date filed (Month, Day, Year)
APR 0

BVAMC

gislrar's Signature

DHMH 17 Rev 1/2001

Registrar

		•	1 - State Registrar	State of Marylan		tificate of Dea			g. No.	10921
Dhu			1. Decedent's Name (First, Middle, Last)					ate of Death	Day Year	3. Time of Death
	sicia edica		Doris Mary Smith		,			ril	1, 2006	3:00 P M
Exa	mine	er	4a. Facility Name (If not institution, give s			4b. City, Town, or Locati			4c. County of Death	
			2818 Washington Blv 5. Social Security Number 6. Sex		(not historia)	Baltimor		ato of Righ	n/a	place (State or Foreign
Fune Direc			10	7. Age (in yrs.		Months Days Hou	rs Min. (Date of Birth Month, Day, NUAYV	19, 1918 Mary	ntrv)
	tor	ŀ	216-20-3915 Usual Residence of Decedent	00	0		Ua	iluai y	19, 1910 Mar	y Land
yland	4	Ì	10a. State 10b. County	10c. Cit	y, Town or Lo	cation			,	0d. Inside City Limits
Mar a-fst		ķ	Maryland n/a	B	altimor	re.				1 ☑ Yes 2 ☐ No
th the		j.e	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
death with the Maryland		Funeral Director	2818 Washington Blv			21230			nited State	
ar de (nue	THE THE TENE	12. Was Decedent Ever in U Armed Forces?	.S. 13. V	Vas Decedent of Hispanic f Yes, specify Cuban, Mex	Origin? (Specify ican, Puerto Rica	Yes or No- n, etc.)	14. Race - Americ Black, White,	
OUSO hours aftu tural', or i		by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		∏Yes 2X No Spec	city:		Specify: Whi	te
within 72 hours after bene.			15. Decedent's Educ		16a. Deced	lent's Usual Occupation		1	6b. Kind of Business/In	dustry
0 2 2	Management	Completed	(Specify only highest grade	completed) College (1-4or 5+)	(Give life. L	kind of work done during r OO NOT use retired)	nost of working			·
d with	9	E	8 (homen	maker			home	
e file	Ven.	Bec	17. Father's Name (First, Middle, Last)			18. M	other's Name (Fir	st, Middle, M	aiden Surname)	
Mental Hy		<u>စ</u>	Charles T. Rollins				Emma E.	Wright		
Mar d 2 sho th and 7 is m			19a. Informant's Name/Relationship (Ty)	·		g Address (Street and Nu			•	
e, F 1 and Health em 27			- Barbara Walls - d			Washington :	BIVO, Ba	-		
DEBILITIONE, MENYJENG ZIZID-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or tiems 23e or 28e-1 show in interval.	5		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	l 6	emetery cren	natory or other place) Veterans			Oc. Location - City or To	
altimor	din's		*4 □Donation 5 □Other (Specify)	Cer	nëterv		4/5/20		rownsville	
Deparie	once.		21. Signature of Funeral Service License	O/O		. Name and Address of Fa				
			23a. Part1. Enter the disease, or compli	cations that caused the deat		07 Wilkens				Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.						Interval Between Onset and Death
Pnysici /Medi		1	disease or condition resulting in death)	Due to (or as a conseq		RUCTIVE	PUCMON	MED	DIZEASE	YEAKS
Examir	ner									
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a soneug	uunes of).					
cate be executed physician and		Examin	Cause (Disease or injury that initiated events resulting in death) Last	·						
DU, se exe cian a		Ξ Ω	resulting in death) cast	Due to (or as a conseq	uence of):					
Cate be e	9 :	dicai								
OX O	, i	Me	IF FEMALE:	3c. If yes, outcome of pregna	ancv				23d. Date of delive	
Bath of atten	5	Physician/Me	in the past 12 months?	1 ☐Live birth 2 ☐ Feta						201
the d	9 .	S		4 □ Pregnant at time of d		Ectopic pregnancy Other (specify)			Month Month	ery Day Year
- 0		2	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnancy Other (specify)				1
tha hed	e la la			9□ Unknown	leath 5□	Other (specify)	art I.	23e. Did tob		Day Year
Tus, F quires tha n signed I	alen ed pin	2	9 Unknown	9□ Unknown	leath 5 □	Other (specify)	art I.	23e. Did tob	Month acco use contribute to t	Day Year
w requires that the death certification is been signed by the attending	Rien ed pinous	2	9 Unknown	9 Unknown atributing to death but not res	leath 5 □	Other (specify)		1 Yes	Month acco use contribute to t s 2 □ No 3 □ Prot 24b, Were auto	Day Year ne cause of death? pably 4 Unknown
e lay	age z	ompieted by	9 Unknown Part II. Other significant conditions con DEM ENTIA	9 Unknown atributing to death but not res	leath 5 □	Other (specify)		1 Yes 24a. Was an autopsy perform	Month acco use contribute to to s 2 No 3 Prot 24b. Were autoprior to co death?	Day Year ne cause of death? pably 4 Unknown psy findings available impletion of cause of
The lay	page	e Completed by	9 Unknown Part II. Other significant conditions con DEM ENTIA #ERNIA 25. Was case referred to medical	9 Unknown atributing to death but not res	leath 5 □	Other (specify)		1 Yes 24a. Was an autopsy perform 1 Yes 2	Month acco use contribute to to the second	Day Year ne cause of death? pably 4 Unknown psy findings available impletion of cause of
The lay	page	o Be Completed by	9 Unknown Part II. Other significant conditions con DEM ENTIA #EN NIA 25. Was case referred to medical examinar?	9☐ Unknown Intributing to death but not res INCALCER #	leath 5 □	other (specify)	lace of Death (Ch	24a. Was an autopsy perform	Month acco use contribute to to the second	Day Year ne cause of death? pably 4 Unknown psy findings available mpletion of cause of 2 No
The lay	page	To Be Completed by	9 Unknown Part II. Other significant conditions con DEMENTIA #ENNIA 25. Was case referred to medical examiner? 1 Yes 22 No 27. Manner of Death	9☐ Unknown Intributing to death but not res INCALCER #	leath 5 に ulting in the ur	other (specify) Inderlying cause given in Proceedings of the control of the cont	lace of Death (Ch	24a. Was an autopsy perform 1 Yes 2 eck only one	Month acco use contribute to to s 2 \(\text{No} \) 3 \(\text{Protocolor} \) Protocolor death? No 1 \(\text{Ves} \)	Day Year ne cause of death? pably 4 Unknown psy findings available mpletion of cause of 2 No
The lay	page	To Be Completed by	9 Unknown Part II. Other significant conditions con DEM ENTIA #ERL NIA 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	9 Unknown Attributing to death but not res ACARCER 4 Iospital: 1 Inpatient 2 Inpatient 28a. Date of Injury	ulting in the ur	other (specify) Inderlying cause given in Proceedings of the second of	lace of Death (Ch.) Nursing Home 28d.	1 Yes 24a. Was an autopsy perform 1 Yes 2 ack only one Aesider Describe how	Month acco use contribute to to s 2 No 3 Protection Protection 24b. Were autoprior to codeath? No 1 Yes code 6 Other (Special winjury occurred)	Day Year ne cause of death? pably 4 □Unknown psy findings available mpletion of cause of 2 □ No
SION OT VITAL KER tending Physician: The lar leath. tor: After this certificate has tor: After disperse	page	To Be Completed by	9 Unknown Part II. Other significant conditions con DEMENTIA #ERL N A 25. Was case referred to medical examiner? 1 Yes 22 No 27. Manner of Death	9 Unknown Attributing to death but not res ACARCER 4 Iospital: 1 Inpatient 2 Inpatient 28a. Date of Injury	ulting in the ur ER/Outpatien 28b. Time of Injury	other (specify) Inderlying cause given in Proceedings of the process of the proc	lace of Death (Ch.) Nursing Home 28d.	1 Yes 24a. Was an autopsy perform 1 Yes 2 ack only one Aesider Describe how	Month acco use contribute to to the second	Day Year ne cause of death? pably 4 □Unknown psy findings available mpletion of cause of 2 □ No
SION OF VICAL INC. tending Physician: The lave leath. total After this certificate has for the disord.	page	Certification: To Be Completed by	9 Unknown Part II. Other significant conditions con DEMENTIA #ER N A 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 Homicide	ospital: 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At h building, etc. (Specification)	ulting in the ur ER/Outpatien 28b. Time of Injury ome, farm, stro	26. P t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes 2	lace of Death (Ch.] Nursing Home 28d.	1 Yes 24a. Was an autopsy perform 1 Yes 2 eck only one Resider Describe how	Month acco use contribute to to acco use contribute to to account a section of the section of t	Day Year ne cause of death? pably 4 Unknown psy findings available mpletion of cause of 2 No No
SION OT VITAL KER tending Physician: The lar leath. tor: After this certificate has tor: After disperse	page	Certification: To Be Completed by	9 Unknown Part II. Other significant conditions con DEMENTIA #EVLAVIA 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural investigation investigation investigation determined 2 Accident 3 Suicide determined	ospital: 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifier: On the basis of examina	Ulting in the ur ER/Outpatien 28b. Time of Injury ome, farm, stre	26. P t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes 2	lace of Death (Ch.] Nursing Home 28d. 2 □ No 28f.	1 Yes 24a. Was an autopsy perform 1 Yes 26ck only one 5 Resider Describe how	Month acco use contribute to to the second	Day Year ne cause of death? pably 4 □Unknown psy findings available mpletion of cause of 2 □ No at Route Number,
SION OF VICAL INC. tending Physician: The lave leath. total After this certificate has for the disord.	page	To Be Completed by	9 Unknown Part II. Other significant conditions con DEM ENTIA #ENLAIA 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural investigation 3 Suicide determined 29a. Certifier (Check only one) 2 Medicel Exemire	ospital: 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specification: To the basis of examina and manner stated.	ulting in the ur ER/Outpatien 28b. Time of Injury ome, farm, stre whedge, death	26. P t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes 2 eet, factory, office	lace of Death (Ch.] Nursing Home 28d. 2 No 28f. I	1 Yes 24a. Was an autopsy perform 1 Yes 2 ack only one 5 Resider Describe how cocation (Strictly or Town, due to the cai	Month acco use contribute to to to s 2 No 3 Protection of the prior to condeath? 1 Yes acco use contribute to to to the prior to condeath? 1 Yes acco death? 1 Y	Day Year ne cause of death? pably 4 Unknown pay findings available mpletion of cause of 2 No at Route Number, tated. o the cause(s)
The lay	pietery filled in by the funeral director, page 2	edical Certification: To Be Completed by	9 Unknown Part II. Other significant conditions con DEM ENTIA #ENLAIA 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural investigation 3 Suicide determined 29a. Certifier (Check only one) 2 Medicel Exemire	ospital: 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specification: To the basis of examina and manner stated.	ulting in the ur ER/Outpatien 28b. Time of Injury ome, farm, stre whedge, death	26. P t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes 2 eet, factory, office	lace of Death (Ch.] Nursing Home 28d. 2 No 28f. I	1 Yes 24a. Was an autopsy perform 1 Yes 2 ack only one 5 Resider Describe how cocation (Strictly or Town, due to the cai	Month acco use contribute to to to s 2 No 3 Protection of the prior to condeath? 1 Yes acco use contribute to to to the prior to condeath? 1 Yes acco death? 1 Y	Day Year ne cause of death? pably 4 Unknown pay findings available mpletion of cause of 2 No at Route Number, tated. o the cause(s)
SION OT VITAL KER tending Physician: The lar leath. tor: After this certificate has tor: After disperse	page	edical Certification: To Be Completed by	9 Unknown Part II. Other significant conditions con DEM ENTIA #ENLAIA 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural investigation 3 Suicide determined 29a. Certifier (Check only one) 2 Medicel Exemire	ospital: 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specification: To the basis of examina and manner stated.	ulting in the ur ER/Outpatien 28b. Time of Injury ome, farm, stre whedge, death	26. P t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes 2 eet, factory, office	lace of Death (Ch.] Nursing Home 28d. 2 No 28f. I	1 Yes 24a. Was an autopsy perform 1 Yes 2 ack only one 5 Resider Describe how cocation (Strictly or Town, due to the cai	Month acco use contribute to to to s 2 No 3 Protection of the prior to condeath? 1 Yes acco use contribute to to to the prior to condeath? 1 Yes acco death? 1 Y	Day Year ne cause of death? pably 4 Unknown pay findings available mpletion of cause of 2 No at Route Number, tated. o the cause(s)
SION OF VICAL INC. tending Physician: The lave leath. total After this certificate has for the disord.	page	edical Certification: To Be Completed by	9 Unknown Part II. Other significant conditions con DEM ENTIA #ENLAIA 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural investigation 3 Suicide determined 29a. Certifier (Check only one) 2 Medicel Exemire	ospital: 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specifier: To the best of examina and manner stated.	ulting in the ur ER/Outpatien 28b. Time of Injury ome, farm, stre whedge, death	26. P t 3 DOA Other: 4 28c. Injury at Work? M 1 Yes 2 eet, factory, office	lace of Death (Ch.] Nursing Home 28d. 2 No 28f. I	1 Yes 24a. Was an autopsy perform 1 Yes 2 ack only one 5 Resider Describe how cocation (Strictly or Town, due to the cai	Month acco use contribute to to to s 2 No 3 Protection of the prior to condeath? 1 Yes acco use contribute to to to the prior to condeath? 1 Yes acco death? 1 Y	Day Year ne cause of death? pably 4 Unknown pay findings available mpletion of cause of 2 No at Route Number, tated. o the cause(s)

			For State Registrar		State of	f Maryland		artment rtificate					iene _{eg. No.}	16	109	22
	—		1. Decedent's Name	(First, Middle,	Last)							2. Date of Dea Month	th	V	3. Time of	f Death
	Physici /Medic		Mary Car	rmelit	a Smith							April 3	Day 2006	Year	7:45	A M
	Examin		4a. Facility Name (If	not institution,	give street and nur	nber)		4b. City, T	Town, or	Location of	of Death		4c. Cour	ty of Deat	h	
			4201 Wilk						timo		0411-			Ltimo		
	Funeral		5. Social Security Nu 216-34-96		3. Sex 1 ☐ M 2[X]F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Months	Days	Hours Hours	Min.	8. Date of Birth (Month, Day	Year)	Co	hplace (State o	or Foreign
	Director		Usual Residence of			66						Apr 15,	1939	Ma	ryland	
	yland yland		10a. State	10b. County		10c. City,	Town or Lo	cation					-		10d. Inside C	ity Limits
	a-fet	ctor	Maryland	Baltin	nore		Balti	more							1 ☐ Yes	2∏ No
	or 28	ire	10e. Street and Num	ber				10f. Zip (Code			1	0g. Citizen o	f What Co	untry?	
	23e	ral	4201 Wilk	ens Ave	enue			:	2122	9			USA			
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28a-f ehow the Madical Examiner must be natified at	Funeral Director	11. Marital Status		Armed Fo		. 13.	Was Decede f Yes, speci	ent of His fy Cubar	spanic Ori n, Mexican	gin? (Spe 1, Puerto i	cify Yes or No- Rican, etc.)		ace - Ame lack, White	rican Indian, e, etc.	
36	s afte	by Fi	1 Never Marrie		d 1 □Yes If Yes, Giv Year or Da	2₩ No		1□Yes 2	No No	Specify:			Spec	ify:	White	Э
21215-0036	hour	ed t	3 - Widowed	15. Decedent's			16a Dece	dent's Usual	Occupa	tion			16b. Kind of	Rusiness/		
15	in 72 n "ne	Completed		y only highest	grade completed)		(Give	kind of work	k done di	uring most	t of worki	ng	TOD. Naid of	DU3111933/1	industry	
212	yiene giene r the	mo	Elementary/Secon	dary (0-12)	College (1		Claim	Proce	esso	r			State	Gove	erment	
	e filed al Hygi other vent,	Be C	17. Father's Name (First, Middle, La	ast)					18. Mothe	r's Name	(First, Middle, I	Maiden Suma	ame)	-	
/lai	should be and Mental a marked o umetic eve	To E	Alfred Pr	aglowsk	ci.					Mary	/ М.	Cooliha	n			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-f ehow eny injury or other treumetic event. It e Medical Examiner must be notified at once.	i. I	19a. Informant's Na						•			l Route Number			, ,	
≥ ′	and ealth m 27 her tr		Stephanie		dowich /				70.7	T. T. T. T.		ltimore				
O.	Pages 1 nent of H int: If ite		20a. Method of Disp 1 Burial 2 □		B □Removal from	Siale		sition (Name natory or oth					20c. Location			
Ē	tmen tent: tent:		° 4 ☐ Donation	5 ☐ Other (Spe	ecify)	Holy		ary Ce		- ,					Maryla	nd
Baltimore,	permit. Page Department i Importent: If eny injury or once.		21. Signature of Fur	eral Service Li	censee							bard Fu				
	40200		230 Part Foulant	~~ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		avend the death						, Balti		Mary.		
	· ·	ı	23a. Part1. Enter the shock, or heart Immediate Cause (F	failure. List or	nly one cause on e	ach line.					cardiac o	r respiratory arm	est,		Approximat Interval Bet Onset and I	ween
	Pnysician /Medical		disease or condition resulting in death)	inai	a. PAN	CREA		CA	NCE	er.		= 1,000		-	6 MO.	NTHS
	Examiner			1	Due to (or as a conseque	nce of):									
op.		ē	Sequentially list con if any, leading to impose cause. Enter Under	ditions, nediate	b	or as a conseque	nce of):									
V	uted d ansit	Examiner	cause. Enter Under Cause (Disease or in that initiated events	ying njury	٠.											
	exec an an rial-tr	Exa	resulting in death) L	ast	Due to (or as a conseque	nce of):									
8760,	cate be executed by sician and the burial-transit	dlcal			d											
9	ng ph as th	Med	IF FEMALE:													
Вох	eath certific attending p for use as	an/I	23b. Was decedent			come of pregnand irth 2 Fetal d		Ectopic pre	gnancy					ate of deli		Vaar
o.	e dea the at	sici	in the past 12 r 1 Pes 2 9 Unknowh	,No	4□Pregn 9□ Unkno	ant at time of dea	th 5 ☐	Other (spe	cify)				l N	lonth	Day *	Year
<u>~</u>	The law requires that the death certifit is that been signed by the attending page 2 should be detached for use as	Physician/Me	Part II. Other signific	cant condition	e contributing to de	eath but not regulti	ing in the w	adorhina an		n in Port I		23a Did tol	2000 HEG 00	ntributo to	the cause of d	loath?
S,	ires tha signed d be del	l by	Tarring Ottoo Organia		o continuating to de	alli bat not 163aili	ing at the u	idenying car	use give	ii iii r dirti.		1 □ Ye	/		bably 4 🗆	- 1
Ö	w requir been si should	Completed														
Sec	has ge 2 a	шb										24a. Was a autops perform	n 240 y ned?	prior to c death?	topsy findings completion of c	available ause of
Vital Records,	n: Tł ficate rr, pa		25. Was case referre	d to medical						8		perform			2□ No	
5	Physicien: r this certific ral director,	o Be	examiner?		Hospital:	npatient 2 EF	R/Outpatien	t 3 DOA	Othou			(Check only on ne 5 Reside		h (0	3.1	
Division of	r this ar this aral d	7: To	27. Manner of Death		28a. Date o	of Injury 2	8b. Time of		c. Injury Work			8d. Describe ho			ary)	
on	nding th. :: Afte	atlo	1 Natural 2 Accident	5 Pending investiga		h, Day Year)	Injury	м		? es 2 □ N	No					
N N	Atte	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	288. Place	of Injury - At homing, etc. (Specify)	e, farm, str	eet, factory,	office		2	8f. Location (St.	reet and Nun	ber or Ru	ral Route Num	ber,
Ö	s afte	Certification;	4 🗆 Homicide		Duligii	ig, etc. (Specify)						City or Town	, State)			
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only	Certifying	Physician: To the kaminer: On the ba	best of my knowle	edge, death	occurred at	t the time	e, date and	d place, a	nd due to the ca	iuse(s) and n	nanner as	stated.)
	the H lin 24 the F aplete	Medical	onej		and manr	ner stated.	TI di lavor li r				ar occurre					
	To To	2	29b. Signature and t	tle of certifier	2	PHYSIC	LAN-	29c.	License		200		9d. Date sign			
Ī	1		100	2.	· m,	. (),-	1, 11			レンさ	> ~ <	BRO)	TICIL	51	6006	
	6		30. Name and addre					Print)	62	4	2	BRO)	DWA	1		
	-01		31. Date filed (Montl				<u> </u>			BAL	IIM	ONE	np	212	05	
	Sta Registr			R 0 7 2	006 See	egistrar's Signatur	600	West of the second								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Johnnie R. Tyson /Medical 04 5:43 A 04 .06 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Under 1 Year If Under 24 Hrs. onths Days Hours Min. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months 13M 2□F Director 238-80-2671 59 09 12 47 North Carolina Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County itam 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director MDPrince Georges Hyattsville 1 Yes 2 □ No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? with 1 5900 Knollbrook Drive 20783 death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or Ite. Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No ģ Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th. Carpet Installer Self Employed permit. Pages 1 and 2 should be fits
Department of Health and Mental Hy
Important: If Itam 27 is marked oth
any injury or other traumests. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Daniel Tyson Josephine Blow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ailene Tyson/Wife 5900 Knollbrook Dr. Hyattsville, MD. 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Horn Funeral Home 04-06-06 Farmville, N.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th. St. N.W. Wash. D.C. 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a cor Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consedue Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of). Box 68760 physician Physician/Medical the use as guipo IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death Aut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA this After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. NASREEN 7600 Carroll Avenue, Takoma Park, MD. 20912 A760 egistrar's Signature 31. Date filed (Month, Day, Year) APR 0 7 2006 State Registrar

			1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H rtificate of L	ealth and I Death		iene () () (10925
	Physici /Medic		1. Decedent's Name (First, Middle, Last,	VAYSB	VRD			2. Date of Deat Month	Day 1 Year 4 200 C	3. Time of Death $9 \cdot 30 \rho$, M
	Examir		4a. Facility Name (If not institution, give NORTHWEST HOSPIT	,		4b. City, Town, or RANDAL			4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sec 114-96-2310		yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APR. 15,	O Bie	thplace (State or Foreign ountry) UKRAINE
	yland		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	the Ma	ector	MD BALTIM 10e. Street and Number	ORE	RAN	DALLSTOWN				1 □ Yes 2 No
	h with 23e or	al Dir	3530 RESOURCE DR	IVE #305		10f. Zip Code 2113	3	1	0g. Citizen of What Co	USA
036	within 72 hours after death with the Maryland ene. then "naturel", or iteme 23e or 28e-f ehow fra Madical Exaction must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🏋 Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 💢 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Menial Hygiene. Importent: if Item 27 is marked other than "naturel; or Iteme 23e or 28e-f show eny injury or other traumatic event, the Madical Enaminal must be notified at ance.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation a completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, AKER	uring most of won	king	16b. Kind of Business	Andustry
gug	be filed Ital Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)		DEVLI	C		ne (First, Middle, A	Maiden Surname)	CHANNONCHI
aryla	should ind Mer marke umatic	ပ္	CHAIM 19a. Informant's Name/Relationship (Ty	pe, Print)	BEYL I 19b. Mailir		RACH nd Number or Ru		City or Town, State, a	SHAKNOVSKI Zip Code)
Š	l and 2 leelth a m 27 le		ALEXANDER VAYSBU			1 JONES V			BALTIMORE,	
more	Pages 1 ent of H nt: If Ite ry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	•	sition (Name of natory or other place EMORIAL P	e) ¦		20c. Location - City or RANDALLS	
Baltimore,	permit. I Departm Importe eny Inju		21. Signature of Funeral Service Doense		22	. Name and Addres	s of Facility S	OL LEVIN	SON & BROS	., INC.
	Physician /Medical Examiner		23a. Part1. Enfor the disease, or complishook or hear tapure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	entre a	er the mode of dying	n, such as cardiac	or respiratory arre	& Lung	Approximate Interval Between Onset and Death
58760,	icate be executed physicien and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a co						
	Attending Physician: The law requires that the death certificate be executed to death. The third has been signed by the etter-third physicien and ecter-third the this certificate has been signed by the iteneral director, page 2 should be detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3 [Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	equires that en signed b	ρ	Part II. Other significant conditions con ATRIAL FIRRIUM			nderlying cause give 2 TEN S/O			acco use contribute to	
Division of Vital Records,	Physician: The law requir this certificete has been si al director, page 2 should I	Completed	-7.40					24a. Was ar autops perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
\	raician s certifii director,	o Be	25. Was case referred to medical examiner?	ospital:	2 ☐ ER/Outpatien	t 3 DOA Othe	-	h Check only one	nce 6 □Other (Spe	
ion of	or Attending Phy after death. Director: After thi in by the funeral of	atlon: T	27. Manner of Death 1 ŪNaural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Injury Work		28d. Describe ho		спу)
Divis	± 2 €	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office		28f. Location (Str. City or Town	eet and Number or Ru , State)	ıral Route Number,
	To the Hospital within 24 hours of To the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of my ter: On the basis of exa and manner stated.	knowledge, death mination and/or inv	occurred at the time restigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
)	To the within	Me	29b. Signature and title of certifier	mapu	- MO	29c. License	number 5 4 2 8 8	29	April 4	14 2006
	1)		30 Name and address of person who co	I Kanga	regelle	Print)	ettire	it this	April 4 pilet Ca	tg
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's S	Signature	all)			-	

Amend item # 17,20b, Per H, (854, 4//05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 30 2006 Bristol White Sr. 0648 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Nursing Home Towson Baltimore | Months | Days | Hours | Min. | May 24,1922 | S. Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⋈** M 2□ F 83 Yrs. 250-14-3561 Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at MD N/A Baltimore 1fXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2857 Woodbrook Ave 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 [\$\fonal2 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Truck Helper Hecht-May Co. 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be and Mental Walter Is marked Bristol White Etta C. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st If Health ar Etta E. White / Daughter 2857 Woodbrook Ave Baltimore MD 21217 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot crownsville Vet. Cem. Date

Date

Date

Date

Line of Dispusition (Name of Date)

Line of Date

Date

Date

Line of Dispusition (Name of Date)

Line of Date

Date

Date

Line of Date

Date

Date

Line of Date

Date

Line of Date

Date

Date

Line of Date

Date

Date

Line of Date

Date

Date

Line of Date

Date

Date

Line of Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Date

Da 1 Murial 2 Cremation 3 Removal from State Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Fineral Service Licens 5240 Reisterstown Rd Baltimore MD 21215 23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death frimediate Cause (Final disease or condition resulting in death) **Physician** Complications 724) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 any, loading to in nediate cause. Enter Underlying Cause (Disease or injury Due to (or as a noneaquence of): Examine as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 X Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? (es 2 d No certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Cther: 4 Nursing Home 5 Residence 6 Dether (Specify) No Spice 1 ☐ Yes 2 ØNo 2 this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending 1 Matural death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 30 2006 30. Name and address of person who completed cause of death (Item 23a) Type, Print) St BALTIMER APRON CHARLES, MD M 2/204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item# 19b, perFH 9854, 4/7/06 TT Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Vear Morrell Younger Washington 8:46 PM 2006 March 29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Since Hospital Cit NIA Baltimore Balhmore If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) April 28, 1949 Maryland 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 219-52-7434 **X**□M 2□F Hours 56 Yrs. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f ehov the Medical Examiner must be notified at 1X Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5348 Nelson Avenue Apt. 1 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Bfack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status 1 Never Married 2 Married 21215-0036 1 Yes XNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced "naturel", nam 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary_(0-12) College (1-4or 5+) 12th Grade Technician United Book Press Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ies 1 and 2 should be fill of Heelth and Mental H I item 27 Is marked oth William Washington Louise Barksdale wife 19a. Informant's Name/Relationship (Type, Print) 195 Maifing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5248 Nelson Ave. Apt.1 Baltimore, MD 21215 Terry R. Hurt-Washington Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 4/6406 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ites
any injury or oth 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris FuneralHome 21. Signature of Fuz ral Service Licental x eros Varno 5240 Reisterstown Rd. Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Asphyxiation /Medical Due to for as a consequence of): Examiner Esophageal (ancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a conv Examiner certificate be executed physicien end s the burial-transit Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of defivery 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year 5 Other (specify) P.0. signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 5 autopsy performed? this certificate 1 ☐ Yes After this certification funeral director, I 25. Was case referred to medical examinar?
1 Pres 2 No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ţ, 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) sedenly eoph 100 MD P40693 April 5, 2006 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) SINA HOSPITAL OF BACTIMORE ALDEN G. PEOPLES, MO 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2006 Registrar

Washing

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20b-c, perFH C35, 4/7/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year 10:47 AM eonard 30 2006 /Medical March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randa 15T Northwes enter Hospita Timore 5. Social Security Number 8. Date of Birth Sept. 5, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Spuntry) **Funeral** Months Days 218-14-7647 Usuat Residence of Decedent 1⊠M 2□F Hours Min. Director 10a. State 10b. County 10c. City, Town or Location f ahow 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ahov the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland 10e. Street and Number mor 10f. Zip Code 10g. Citizen of What Country? 212 by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. within 72 hours after 1 VYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame, Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code (daughter) permit. Pages 1 and 2 a Department of Health at Important: If Item 27 is any injury or other trau once. 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Crownsville Cemetery Burial 2 Cremation 3 Removal from State Cr.wnsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility Joseph Li Rus SAtu Homert 23a. Part / Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failtire. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple organ system
Due to (of as a consequence of): /Medical Examiner stemic inflammetor sponse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): for use as the burial-transit 3ilateral Due to (or as a consequence of): attending physician and Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the at Id be detached fo 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 1 TYes 2 No 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 212 No 2 as case referred to medical examiner? diabetes Osteoarthritis 1 ☐ Yes 2 ☐ No of Vital 1 Yes Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No မှ 1 Impatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; or Attending Division 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 - Homicide 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Boolons M D28462 March 30 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boston Center Randallstown, Maryland 21133 Northwest Hospita 31. Date filed (Month, Day, Year) Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year AM AP(E) 5 9000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) ARE OAKTRS BASTIMORE 13 **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) M 2DF Director 60 Yrs. 318,00,0108 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Mudical Examinar must be notified at Director 1 ☐ Yes 2 No MARYLAND BALTIMORE EARNE) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BLVD. Itеma 23a 8833 31337 Funerai U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Amed Forces?

MSYes 2 \(\text{No } 1 \cap 3 \text{V} = 1 \text{Ves, Give} \)

Year or Dates: \(\frac{3}{3} \text{V} \) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö Specify: WHITE Completed by 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) 13702 BLACKSMITS BITHLEHEM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EMARLES 2 A11272 HOOL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 CHARLOTTE VINERALION isol Gen Bun ROAD Glen ARM MARCHAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) APRIL 8 20c. Location - City or Town, State Department of P Important: If ite eny Injury or ot once. ₩ Burial 2 Cremation 3 Removal from State HOLY KOSARY 4 ☐ Donation 5 ☐ Other (Specify) 1 Showitza0 JARY LANC 2006 21. Synthus of Funders Server Licensee 22. Name and Address of Facility TEMORILS 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bacterial disease or condition resulting in death) presmonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a nonsequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Box 68760. Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) P.O. | signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ASCVD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown certificate has been si rector, page 2 should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed? 1 Yes 2 100 Hospitel or Attending Physicien: After this certific funeral director, 25. Was case referred to medical 26. Place of Death | Check only one examiner' Other: 4 Mursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funerel Director: All completely filled in by the fu investigation 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. (Check only 110 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) - mane 5 86 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) walthor Boulevase Monias 8500 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State APR 0 7 2006 Registrar

Susan A. Ward 06-02223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	,	
State of Maryland / Department of Health and Mental Hygiene	е	n		1
Cortificate of Pooth		U	U	1

	1 - For State Registrar		State of M	,	-	rtificate				1	Reg. No.	Ub	10930
	1. Decedent's Name	e (First, Middle, La	ist)						2	Date of Dea	ath		3. Time of Death
siciar	Curan I	Ward								Month March	1.31,20	06 Year	12:40 PM
edica ımine:	4	f not institution, giv	re street and number)		4b. City,	Town, or	Location of	Death			ty of Death	
	Union M	Memorial	Hospital			В	alti	more				n/a	
ral	5. Social Security N	lumber 6.5	Sex 7. A		last birthday	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. g. Min.	Date of Birt (Month, Da	h		place (State or Foreign
tor	580.25.	6706	201	44	Yrs.					01/2	4/1962	Engl	and
	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or L	ocation							10d. Inside City Limits
į	MD	Baltim	ore City	Ra	ltimo	re							1. Yes 2 □ No
Director	10e. Street and Nu		010 0101			10f. Zip	Code				10g. Citizen of	What Cou	ntry?
	3601 Gre	enwav				21	218			`	Briti	sh	
To Be Completed by Financial Director	11. Marital Status		12, Was Deceden Armed Forces	Ever in U	.S. 13.	Was Deced	lent of Hi	ispanic Orig	in? (Specif	y Yes or No- an, etc.)	- 14. Ra	ce - Ameri	
ū	1 Never Marri	ied 2 Married	1 Yes 2 7	No		1 Yes 2		Specify:	ruento mic	an, ecc.)	Spec	eck, White,	etc.
2			Year or Dates									BLa	
Completed	(Spec	15. Decedent's E cify only highest gra	ducation ade completed)		(Give	dent's Usua kind of wor DO NOT us	k done o	turina most	of working		16b. Kind of		dustry
1	Elementary/Seco	ndary (0-12)	College (1-4or			maker		,			Own H	ome	
2		(First, Middle, Last)	2	поше	maker		18. Mother	's Name (F	First, Middle,	Maiden Suma	ıme)	
To Be	Odel A	dams						Mega	n De	ygoo			
-		ame/Relationship (Type, Print)		19b. Mail	ng Address	(Street a	and Number	or Rural R	loute Numbe	er, City or Town	n, State, Zip	Code)
	Kibian A	Adams-Gree	ne/Sister		360	1 Gree	enwa	y Balt	imor	e, MD	21218		
once.	20a. Method of Disp		_	20b. F	Place of Disp emetery, cre	osition (Nam	ne of	a)	Date		20c. Location	- City or To	own, State
			Removal from State (y)	'	nesape			1		pr 10	Beltsv	ille,	Maryland
a	21. Signature of Fu	ineral Service Lice	nsee			2. Name and	d Addres	s of Facility					
and and	25-2	Foul a	1 willis	16/40	43						natives Baltimo:	re. Ma	ryland 2128
	23a. Part1. Enter the shock, or hea	he disease, or com	plications that cause one cause on each	d the deat		ter the mode	e of dying	g, such as c	ardiac or re	espiratory ar	rest,		Approximate Interval Between
an 🖠	Immediate Cause	(Final	1140	ero.	5000	wtii	0	andi	OTOM	ula	Da	110	Onset and Death
al	resulting in death)	(Due to (or a	s a conseq				POP OF E	01000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
ier	Sequentially list co	nditions.	b										
Fxaminer	n any, leading to in cause. Enter Unde Cause (Disease or	orlying	Due to (or a	a comoqu	uarica ol).								
edical Examin	that initiated events resulting in death)	•	c. Due to (or a	s a consen	neuce ot).								
T.			240 10 (0) 4	, a oonsoq	201100 01).								
edical			_ d.									_	
, ,	IF FEMALE:		23c. If yes, outcome	e of pregna	incv						224 D	ate of deliv	200
Physician/M	in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pre □ Other (spe						lonth	Day Year
8	1 Yes 2 D 9 Unknown	_INO	9☐ Unknown										
by Physician/W		icant conditions	contributing to death	but not res	ulting in the u	inderlying ca	ause give	n in Part I.		23e. Did to	obacco use co	ntribute to t	he cause of death?
leted b										1 🗆 Y	res 2⊠No	3 🔲 Prob	pably 4 ∐Unknown
Jete	6									24a. Was		. Were auto	psy findings available
										autop	rmed?	prior to co death?	mpletion of cause of
9 0 0										400		4 1 1/	2 No
e Completed	25. Was case refer	red to medical						26. Place	of Death //		2) No	1 🗌 Yes	2□ No
o Be Com	25. Was case refer examiner?		Hospital: 1 _ Inpat	ent 2X	ER/Outpatie	nt 3 DO	A Othe	00	- 3	Check only o	ne)		
To Be	25. Was case refer examiner?	No h	28a. Date of Inj	ury	28b. Time o		^	er: 4 🗆 Nurs	sing Home	5 🗌 Resid		ther (Specif	
To Be	25. Was case refer examiner?	No h 5 Pending investigation	28a. Date of Inj (Month, D	ury			Bc. Injury Work	er: 4 🗆 Nurs	sing Home	5 🗌 Resid	ne) lence 6 □Ot	ther (Specif	
To Be	25. Was case refer examiner?	No h 5 🖸 Pending	28a. Date of Inj (Month, D	ury ay Year) ijury - At ho	28b. Time of Injury	M 28	8c. Injury Work	er: 4□ Nurs at c?	sing Home 28d	5 Resid	dence 6 On	ther (Specif	
To Be	25. Was case refer examiner?	No h 5 Pending investigation 6 Could not b	28a. Date of Inj (Month, D	ury ay Year) ijury - At ho	28b. Time of Injury	M 28	8c. Injury Work	er: 4□ Nurs at c?	sing Home 28d	5 Resid	dence 6 On	ther (Specif	y)
To Be	25. Was case referexaminer? 202Yes 2 27. Manner of Deat 1	No h 5 Pending investigation 6 Could not be determined	28a. Date of Inj (Month, D)	ury ay Year) ijury - At ho tc. (Specifi	28b. Time of Injury	M 28	8c. Injury Work 1 1	er. 4 Nurs	280 o 281	5 Residence only of the control of t	nel dence 6 On now injury occu Street and Num m, State)	ther (Specification of the state of the stat	y) al Route Number, tated.
To Be	25. Was case referexaminer? **EXYes 2 □ 27. Manner of Deat 1 Natural 2 □ Accident 3 □ Suicide 4 □ Homicide 29a. Certifier (Check only one)	No h 5 Pending investigatio 6 Could not b determined	28a. Date of Inj (Month, Din 19 28e. Place of Irj building, e	ury ay Year) jury - At ho to. (Specify t of my kno of examina	28b. Time of Injury	M 28 M reet, factory, th occurred a livestigation,	Bc. Injury Work 1 1	er: 4 Nurs	280 o 281	5 Residue to the dat the time, d	nel dence 6 On flow injury occu street and Num in, State) cause(s) and in date and place	ther (Specification of the state of the stat	y) al Route Number, tated. to the cause(s)
Certification: To Be	25. Was case referexaminer? REAYes 2 27. Manner of Deat 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	No h 5 Pending investigatio 6 Could not b determined	28a. Date of Inj (Month, D) ne 28e. Place of Ir building, e	ury ay Year) jury - At ho to. (Specify t of my kno of examina	28b. Time of Injury	M 28 M reet, factory, the occurred a livestigation, 29c.	8c. Injury Work 1 1 1 , office at the tim in my op	er. 4 Nurs	280 o 281	5 Residence only of the control of t	nel dence 6 On now injury occu Street and Num m, State)	ther (Specification of the state of the stat	tated. Day, Year)

S. P. HOGA

31. Date filed (Month, Day, Year) 32. State APR 0 7 2006 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

Physician	n	1. Decedent's Name (First, Middle, Last) Walter Coleman Wood	olum	2. Date of Death Month March	Day Year	3. Time of Death
/Medica Examine	r	4a. Facility Name (If not institution, give street and number) 4b. City, To 405 DONEGAL DRIVE	own, or Location of Death		4c. County of Dea	
Funeral Director		5. Social Security Number 405-03-0774 6. Sex XX M 2 F 7. Age (In yrs. last birthday) Months Wonths Usual Residence of Decedent	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,) 07-08-19	9. Bi	rthplace (State or Fore KENTUCKY
be notified at		10a. State 10b. County 10c. City, Town or Location	TOWSON			10d. Inside City Lim
st be not	5	10e. Street and Number 10f. Zip C 405 DONEGAL DRIVE	21286	100	g. Citizen of What C	-
	Dy rur	11. Marital Status 1 Never Married 2 Married X Was Decedent Ever in U.S. Armed Forces? X Y Y S 2 No 1938 - If Yes, Sive Year or Dates: 1940 11. Was Decedent Ever in U.S. Armed Forces? X Y Y S 2 No 1938 - If Yes, Sive Year or Dates: 1940	nt of Hispanic Origin? (Sp. y Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
d other then "natu event, the Medical	Completed	Elementary/Secondary (0-12) 4 College (1-4 or 5+) X-RAY TE	done during most of work.	ing 16	HOSPITA	
even even	0 00	17. Father's Name (First, Middle, Last) WALTER S. WOOLUM	18. Mother's Name CYNT	e (First, Middle, Ma	widen Sumame) WILLIAMS	
72	_	JOHN FOX GRAHAM, JR. (EXECUTOR) 24 IVY REAC	Street and Number or Rura H COURT, COC	KEYSVILL	E, MARYLA	ND, 21030
ent: If item ury or othe	;	20a. Method of Disposition **XXBurial 2	RCH CEM.04-0	05-2006 T	Oc. Location - City o AYLOR ISL	Town, State AND, MD.
Importent: If it any injury or o			Address of Facility		1050 V	UDK DUVD
physician and strength and stre	Ulcal Exa	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tary, leading to minimize the cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause one each line. List one cause one each line. List one cause one each line. List one cause one each line. List one cause one cause one each line. List one cause one cause one cause one cause one cause one cause one cause one cause one cause one cause one cause one cause one cause one cause one	Parlure			Interval Between Onset and Death Y Mos.
detached for use as to be detached for use a	iyaicidii/ime	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (spec			23d. Date of de Month	elivery Day Year
be o	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cau	se given in Part I.	23e. Did toba		o the cause of death? robably 4 □Unknow
page 2				24a. Was an autopsy performe	prior to	utopsy findings availab completion of cause of s 2 No
After this funeral di	2	25. Was case referred to medical examiner? 1	Other: 4 Nursing Hor Injury at Work? 1 Yes 2 No	28d. Describe how	injury occurred et and Number or R	
To the Funerel Director: completely filled in by the Medical Certifical		29a. Certifier (Check only Medicel Examiner: On the basis of examination and/or investigation, in	the time, date and place, a	and due to the caus	se(s) and manner a	s stated.
II OD	3	one) and manner stated.	, apartially additionally	- unio unio, gale	I. Date signed (Mon	

ORIGINAL

			1 - For State Registrar		larylar		artmer ertificat			d Mental Hy	yglene Reg. No. 006	10932
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, L Robert H Aa. Facility Name (If not institution, gi	erman Wirt			4b. City,	Town, or	Location of D	2. Date of D Month Apri eath	D- 14	
9	Funeral Director				ge (In yrs. 90	last birthda Yrs.	/) If Under Months	TOW 1 Year Days	If Under 24 I	Hrs. 8. Date of B (Month, D April	Baltimus 9. E	ore Birthplace (State or Foreign Country) aryland
	he Maryland (8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Md. Baltimo	ore		y, Town or eiste:	rstown					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	within /2 hours atter death with the Maryland ene. Than "natural", or iteme 23a or 28a-f show te Madical Examinar must be notified a	Funeral Dire	10e. Street and Number 120 First 11. Marital Status	12. Was Decedent	Ever in U	.S. 13		1136	spanic Origin?	(Specify Yes or Nuerto Rican, etc.)	10g. Citizen of What U.S.A.	merican Indian,
5-0036	2 hours atternation in the second sec	b	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's 8	1 XYes 2 If Yes, Give Year or Dates:	N.1 -	II	1 Yes	2 XNo	Specify:		Specify: W	hite
. N	Hygi Ther	e Completed	(Specify only highest given the secondary (0-12) 8 17. Father's Name (First, Middle, Las	College (1-4or	5+)		e kind of wo DO NOT us rvice		uring most of		Suburban	•
Maryland	z snould be and Mental is marked craumatic even	To Be	Robert B.	(Type, Print)					Eliza	abeth Sus	an Brunnet	o, Zip Code)
altimore, r	nit. Fages 1 end ariment of Health ortant: If Item 27 injury or other t		Robert B. Wirts 20a. Method of Disposition 1 2 Burial 2 Cremation 3 1 4 Donation, 5 Other (Speci	Removal from State	20b. F	lace of Dier	ocition (Nan	no of		Data	om, Pa. 17 20c. Location - City of 1006 Owings	
Dail	Departitude in the permit in t		21. Signature di un al Gervice Lies 23a. Partit. Enter the disease, or con	County	d the deat	I	2. Name an Ckhar 1605	dt F Reis	uneral terstov	Chapel, vn Rd., O	P.A. Wings Mills	s, Md. 21117
	nysician /Medical Examiner		shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	a conseq	d~ ∂ uence of):	F F		26	حمرام	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	Interval Between Onset and Death
oo, 1	cien end burial-transit	icai Examiner	Soque thatly for conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):	<u> </u>	1		7. 0g	, x-1	years
. DOX O	e attending p	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal	death 3	□Ectopic pro □ Other (spo		Si	1.5	23d. Date of d Month	elivery Day Year
ecords, r.O	een signed ? een signed ? nould be det	þ	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the	underlying ca	ause give	n in Part I.		tobacco use contribute Yes 2 No 3 ☐ F	to the cause of death? Probably 4 □Unknown
ב ב	ifficete hes b	e Completed	25. Was case referred to medical						OC Plans of F	24a. Was auto perio	psy prior to ormed? death? 2 No 1 □ Ye	
DIVISION OF PRESIDENCE	within 24 hours after death. To the Funeral Director: After this certificate hes completely tilled in by the funeral director, page 2.	Certification: To B	exammer? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined.	28e. Place of Inj building, et	y Year) 2006 ury - At ho	28b. Time of Injury	Рм	A Other Bc. Injury Work 1 Y	4 🗋 Nursing	Home 5 Resi 28d. Describe Fall J 28f. Location (City or To	dence 6 Other (Sp how injury occurred	Haral Route Number.
Joseph ed	in 24 hours he Funeral pletely tilled	edicai	29a. Certifier (Clisik only one) Certifying Place Medical Example	nysician: To the best miner. On the basis or and manner sta	examinai	wledge, dea ion and/or ir	th occurred any estigation,	at the time in my opi	e, date and pla nion, death oc	on and due to the	cause(s) and manner a date and place, and du	no atat-d
F	Tot	Σ	29b. Signature and title of certifier 30. Name and address of person who AMON J. CHAN	um	noth (Itom	220) /T		License D S		3	29d. Date signed (Mor APRIL 6 2	nth, Day, Year)
-	Sta Registr	te	31. Date filed (Month, Day, Year)	WES WO 6				+ /	BATIM	re un 2	1204	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item#5,perFH, \$255,58 M TT Amend item#5,perFH, \$25 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apyonin 4, **Physician** 2006 5:00 am Jane B. Wotton /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street end number) Examiner Lutherville College Manor 5. Social Security Numbe 054-01-7689 056 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Jamonth, 7ay, 12916 9. Birthplace (State or Foreign Rewy) Jersey **Funeral** 1 M 2 F Days Hours 90 Yrs. **Director** Usual Residence of Decedent filed within 72 hours efter death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28e-f ahow the Medical Examiner must be notified at Baltimore Towson 1 Yes 2X No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21286 7405 Rocksham Drive Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Balt. Public Schools permit. Peges 1 and 2 should be filed w Depertment of Health and Mental Hygien. Important: if Item 27 is marked other the any injury or other traumeting. 18. Mother's Name (First, Middle, Meiden Sumame)
Jane S. Vankirk 17. Father's Neme (First, Middle, Last) Be Charles L. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3341 Berkshire Drive Bloomfield, MI 48301 Barbara Rothgery/ Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State emetery, crematory or other plece) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4-5-06 Towson, Md. Hilltop Service Co. 4 ☐ Donation 5 ☐ Other (Specify) Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical C#RONIC OBSTRUCTIVE PILMONARY Examiner Due to (or as a consequence of) Examiner Attending Physicien: The lew requires that the death certificate be executed physician end s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) ettending p use as Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha causa of death? been signed by t should be detect 3 Probably 4 Unknown 1 ☐ Yaa 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy this certificate hes 2 No 1 Tes 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannet of Death 28b Time of Certification: Diractor: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) ò 24 hours efter of Funeral Dirac 4 Homicide 5 To the Hospital o within 24 hours of To the Funeral D 11 Cartifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier edical (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 2006 MD 016619 Cun arasoar 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) LUTHERVILLE, MD. 21093 AVE. 300 W SEMINARY C.VERGARA-SOARES

State Registrar

APR 0 7 2006

31. Date filed (Month, Day, Year)



			1 - For State Registrar	State of Maryland /		tificate of L			Reg. No.	16	10934
	Physici		Decedent's Name (First, Middle, Last) Dorothy	Arnel		Yeage	er	2. Date of Dea Month April	Day 4	Year 2006	3. Time of Death 5:34PM M
	/Medio Examir		4a. Facility Name (If not institution, give st	reet and number)			Location of Death	7.51.1.		y of Death	J. J. T. 11
			213 Magothy Bea			Pasad				Arund	
h	Funeral Director	2	5. Social Security Number 6. Sex 12-03-9768 1□	7. Age (In yrs. last 89	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day Oct. 16	, Year) 5,1916	9. Birthp Cour North	lace (State or Foreign try) Carolina
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation				1	Od. Inside City Limits
	Maryl f sho	to	Maryland Anne Aru	ndel	Pasa	dena					1 ☐ Yes 2 X No
	h the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?
	ath wil	raic	213 Magothy Bea			1	1122		USA		
936	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Heelth and Menta! Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, the Mudical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □ Yes 2☑ No		ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americ ack, White, fy: Wh	
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade	ation 16	(Give	lent's Usual Occupa	lurina most of worki	na	16b. Kind of I	Business/In	dustry
121	hen hen	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	lite.	DO NOT use retired,)		l DNI		
d 2	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)	2	Nur	se	18. Mother's Name	(First, Middle,	LPN Maiden Suma		oital
lan	ould be Mental arked o	To Be	Lester	S Knight			Susan	E1	izabet	h	Albertson
Maryland	2 should be filed withir and Mental Hygiene. ie marked other then eumatic event, the Mental Count, the		19a. Informant's Name/Relationship (Typ	9, <i>Print)</i> 1	9b. Mailir	ng Address (Street a	and Number or Rura	I Route Numbe	r, City or Town	, State, Zip	Code)
	t and teelth im 27		Frank Shaulis F 20a. Method of Disposition	ersonal REP. 1	10 E	. Lexingt		E300 Ba	1 timor 20c. Location		
nor	Pages nent of the ant: if ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State ceme	tery, cret	natory or other place	9)				
Baltimore,	# E E E .		4 □Donation 5 □ Other (Specify) 21. Signatire of Funeral Service (Icen)			ematory . Name and Addres	4/5/2		Balti		
ä	Depa Impo any i		Jana X	1		3111 Mou	ntain Roa	llings d Pasad	ena MD	1 HOM6 21122	P.A.
	Physician /Medical		23a. Part f. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Declared in each line. Due to (or as a consequence	ire	er the mode of dying	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death 2 Mo
V	Examiner transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):						
68760,	tificate be executed ig physicien and as the burial-transit	/edical Ex	d.	Due to (or as a consequence	08 Of):						
.O. Box	The law requires that the death certificate be executed ste has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)				ate of delive onth	ory Day Year
<u>α</u>	es that igned b be deta	by Pr	Part II. Other significant conditions cont	ibuting to death but not resulting	g in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	ntribute to th	ne cause of death?
Records,	w require been sig should b		- Till	fusion				1 🗆 Y	es 2□No	3 Prob	ably 4 Denknown
ecc	e law r has be je 2 sh	Completed	Chapetin	Mellitu)			24a. Was autop	an 24b sy	Were auto	psy findings available impletion of cause of
a H		_	Empl	ugsema		· · · · · · · · · · · · · · · · · · ·		perfor 1 ☐ Yes	2 10 No	death?	20 No
Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/	Outnatier	t 3 DOA Othe	26. Place of Death 9:: 4 ☐ Nursing Ho			her (Specif	el .
ו סל	g Phy terthis neral o		27. Manner of Death		o Time of			28d. Describe h			//
sior	Attending r death. ector: After by the funer	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(, 25)	,,		res 2 □No				
Division	9 # E	Certification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory, office		28f. Location (S City or Tow		ber or Rura	d Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	Medicai (29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examination	cian: To the best of my knowled er: On the basis of examination and manner stated.	dge, deatl and/or in	n occurred at the tim vestigation, in my op	ne, date and place, pinion, death occurr	and due to the ded at the time, d	cause(s) and n date and place	nanner as s , and due to	taled. the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	arga	~	29c. License	1322_		29d. Date sign	ed (Month,	Day, Year)
	10		30. Name and address of person who con	npleted cause of death (Item 23:	a) (Туре, U30	Print) MOZ	KTAIN	ROA	D, PA	SADE	NA RAID

DHMH 17 Rev 1/2001

State Registrar

		1 - For State Registrar	State of Maryland	-	artment of Healt			ene 006	10935
		Decedent's Name (First, Middle, Last)					Date of Death		3. Time of Death
Physic		Carolyn Louise	Yates				Month oril 6	Day Year , 2006	5:55AM M
/Med Exam		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or Local	tion of Death		4c. County of Deat	th
		Fairhaven Health	Care Center		Sykesvill	le		Carro	11
Funera	1	5. Social Security Number 6. Sex		ast birthday)	If Under 1 Year If Ur Months Days Hou	nder 24 Hrs. 8.	Date of Birth Month, Day, Y	9. Birt	thplace (State or Foreign
Directo		063-36-3884	M 2√ F 95	Yrs.	Worting Days 1100		ne 26,		MD
P		Usual Residence of Decedent	10- 00	, Town or Lo					10d. Inside City Limits
anylan show	_	10a. State 10b. County MD Carrol1	1	Sykes					1 Yes 2 No
Ba-f	Director	331331		Dyrees					
iff the or 2	a a	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	
within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Modical Exertinal tencilitied at		7200 Third Avenue			2178			USA	
r de r	Funeral	TT. Wanta Gatos	2. Was Decedent Ever in U. Amed Forces?	S. 13.	Was Decedent of Hispanion of Yes, specify Cuban, Me	ic Origin? (Specify oxican, Puerto Rica	Yes or No- in, etc.)	14. Race - Ame Black, Whit	
S affe	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give X		1 ☐ Yes 2 ☐ No Spe	ecify:		Specify: Whi	ite
"natural", or	9	3 X Widowed 4 □ Divorced	Year or Dates:	16a Dasse	dent's Usual Occupation		16	b. Kind of Business/	
72 r	Completed	15. Decedent's Educ (Specify only highest grade		(Give	kind of work done during DO NOT use retired)	most of working	, ,	D. Killa of Dasifiess	industry
withii ane. than	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)	ш	omemaker			Domesti	ic
		17. Father's Name (First, Middle, Last)				Mother's Name (Fi	rst, Middle, Ma		
ylaild &) Be	Robert H. White				Alice 0	ahourn		
should be filed and Mental Hygi a marked other umatic event, I	ို	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street and N				Zip Code)
d 2 shou th and M 7 Is mar traumat		Dr. David Yates (S		Still	house Road	Rt. 4. F	rankli	n. TN 3706	54
ore, Mal yial es 1 and 2 should b of Health and Ment filem 27 is marked r other traumatic		20a. Method of Disposition	20b. P		sition (Name of natory or other place)	Date		c. Location - City or	
Deficiency of the pages 1 are postured to the pages 1 are proportion of the pages 1 are proportion of the pages 1 are proportion of the pages 1 are proportion of the pages 1 are proportion of the pages 1 are pa		1 Burial 2 Cremation 3 R	emoval from State		natory or other place) cy Cremation	1/7/20	06 5	kesville,	MD
it. P. rtani		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License				Engility			
permit. Pages 1 Department of H Important: If itel any injury or oth		2,	Haicet	Ī	Ame and Assess of F IAIGHT FUNER Sykesville,	RAL HOME MD 21784	& CHAPI (410)	L PA (Bo)-795-1400	ox 195)
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on					spiratory arres	t,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Infec	4.0	s Colit	tis			Onset and Death
/Medica	1	resulting in death)	Due to (or as a consequ	uence of):					
Examine	r	Sequentially list conditions, b							
D #	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):					
nd	Examiner	that initiated events c		5)					
e exe tan a urial-	Ä	resulting in death) Last	Due to (or as a consequ	uence of):					
of ou, cate be executed only sician and the burial-transit	dlcal								
ntifical ing plans to a set to	Med	IF FEMALE:							
BOX DO leath certific attending p	an/i	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal	Ideath 3□	Ectopic pregnancy			23d. Date of de Month	livery Day Year
e dea he at	Sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5	Other (specify)				,
at the dby the etache	Physician/Me	Part II. Other significant conditions con	tributing to death but not soon	ulting in the u	adorbija agusa gusa in l	Port	23e Did toha	course contribute to	o the cause of death?
	þ	Affers & lars f.				z'sevse			robably 4 Dunknown
w require been signaled	Completed by	7990	J. 7. 7		- 0	2000	1		
law i	pie						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
The The ate h page	5						performe 1 ☐ Yes 2 ☐	ed? death? PNo 1 ☐ Yes	2 □ No
OI VIIAI LEOPhysician: The lave this certificate has all director, page 2	Be	25. Was case referred to medical examiner?				Place of Death (C	heck only one)		
hysik hysic his co	၉	1 Yes 2 No		ER/Outpatier	The second secon			ce 6 □Other (Spe	cify)
ng P ng P fter t		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?		. Describe how	injury occurred	
SIO leath.	cat	2 Accident investigation 3 Suicide 6 Could not be			M 1 ☐ Yes		1		Cauta Mumbas
DIVISION OT VITAL MECOTOS, to a Attending Physician: The law requires thater death. Director: After this certificate has been signe in by the tuneral director, page 2 should be e	Certifications	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, tarm, str y)	eet, factory, office	281.	City or Town,	et and Number or Ri State)	urai moule ivumber,
urs af						7/	al 4 4 -		- stated
DIVISION OF VITAIN To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, and the funeral director, the funeral director director, the funeral director director, the funeral director director director director director.	Medical		eicien: To the best of my kno ner: On the basis of examina						
the the	Med	29b. Signature and title of certifier	and manner stated.		29c. License num	nber	290	d. Date signed (Mont	th, Day, Year)
5 2 5 0	-	Police J. W	Man. Mr.	0	0338			4/6/20	
								,	
12	/	30. Name and address of person who co	mpleted cause of death (Item	п 23а) (Гуре,	erint)	· O.	Ktis	for for	Nel 2113
10		31. Date filed (Month, Day, Year)	32 Registrar's Signa						
Regis	State Strar	APR 0 7 200		· And	will .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM/1 PER PHY #11 17 PER INF C857 7/6/06 WS

State of Maryland 7 Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 IRENA OLDAKOWSKA YOST **Physician** 11:48 P M March 25, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🖾 F 1915 Yrs. 14, Poland Feb. 91 Director 051-42-8037 Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: if item 27 ie marked other than "naturel", or items 23a or 28e-f show ury or other traumatic event, the Madical Expirition must be invitibled. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1⊠Yes 2 No Director MD Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5215 West Cedar Lane 20814 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: 1 ☐ Yes 2 ☑ No Specify. White Completed by 3 Widowed + Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Be OLDAKOWSKI Casimir Oldakowska Edmunde Gruszczynska မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10017 310 East 46 Street, New York, NY Felicity Yost - Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: if eny injury or 04/03/2006 4 Denation 5 Other (Specify) Watertown, NY Brookside Cemetery 22. Name and Address of Facility Cleveland Funeral Home, Inc. 21. Signature of Funeral Service Licensee 13601 404 Sherman Street, Watertown, NY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final vecmonis Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner inding physiclen and use as the burial-transli 7Heros Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy 2 Fetal death Year ò Month Day 4 Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy director, page 2 1 ☐ Yes 2 ☐ No certificate 2 X No 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 2 1 Tyes 21000 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? in by the funeral 27. Manne of Death 28d. Describe how injury occurred 28b. Time of Medical Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗍 Homicide hours after filled within 24 hours a
To the Funerei I
completely filled 1 [Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ne and address of person who completed cause of death (Item 23a) (Type, Print) 8600 OLD GEORGETOWN RD., BETHESDA, MD 20814 SWANN, M.D. WILLIAM B. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006

Registrar

			1 - For State Registrar	State of Maryland / De	partment of Hea ertificate of De		lental Hygie	ZIIIII	10937
ı	Physici		1. Decedent's Name (First, Middle, Last) Geoffrey Trevor	Armbrister			2. Date of Death Month	Day Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give s		4b. City, Town, or Loc	cation of Death	March 22	2. 2006 4c. County of Dea	6:55 A "
	Funeral		6670 Hillandale F 5. Social Security Number 6. Sex	7. Age (In yrs. last birthd		Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	Montgom 9. Bir	ery thplace (State or Foreign ountry)
	Director		040-26-8585 Usual Residence of Decedent	M 2□F 72 Yrs	. Jays 11	IOUI'S IVIII'.	Dec 4 19		nnecticut
	anyland	_	10a. State 10b. County MD Montgomer	10c. City, Town or					10d. Inside City Limits
	r 28a-f	Director	MD Montgomer 10e. Street and Number	y Chevy	Uhase 10f. Zip Code		10a.	Citizen of What Co	1 ∑Yes 2 □ No
' 0	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Beginnershift if them 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic evant, the Madical Examiner must be notified at once.	Funeral Di	6670 Hillandale R 11. Marital Status 1 □ Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1.0.5.6	20815 3. Was Decedent of Hispar If Yes, specify Cuban, N	nic Origin? (Spe Mexican, Puerto	Un	ited Sta 14 Race - Ame Black, Whi	tes encan Indian, e, etc.
903	ural', or	d by	3 ☐ Widowed 4 ☐ Divorced	1 Dyes 2 No 1936— If Yes, Give Year or Dates: 1958	1 ☐ Yes 2 🖰 No Si	pecify:		Specify: W	nite
Baltimore, Maryland 21215-0036	d within 72 h giene. rr then "natu the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	cedent's Usual Occupation ive kind of work done durin e. DO NOT use retired) urnalist	n ng most of worki	ing Au	thor / M	•
ryland	nould be file d Mental Hyg narked othe natic evant,	To Be C	17. Father's Name (First, Middle, Last) Geoffrey Campbell			Mary M			
ā ≥	nd 2 st alth and 27 ia n r traun		19a. Informant's Name/Relationship (Type Judith C. Armbrist		ailing Address <i>(Street and i</i> 70 Hillandal				. ,
imore,	Pages 1 and the ment of Heament: if item ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b Place of Dis	position (Name of rematory or other place) nal Cremator		late 200	Location - City or Churc	Town, State
Balt	permit. Departr Imports any inj		21. Signature di Funeral Service License	a !	22. Name and Address of 5130 Wiscons	in Ave.			
	Physician		23a. Part1. Enter the dispase, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	anons that caused the death. Do not decause on each line. Metastatic Panci			r respiratory arrest,		Approximate Interval Between Onset and Death 6 months
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):					
8760,	be executed sicien and burial-transit	dical Examiner	Sequentially list conditions, it arry, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):					
.O. Box 687	at the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		B Ectopic pregnancy G Other (specify)			23d. Date of del Month	ivery Day Year
rds, P	es to go es	2	Part II. Other significant conditions cont	nbuting to death but not resulting in the	underlying cause given in	Part I.			the cause of death?
_	n: The law requires that the licete has been signed by th. r, page 2 should be detache	Completed					24a. Was an autopsy performed	? prior to death?	topsy findings available completion of cause of
Vital	Physician: this certifice al director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Out		<i>(Check</i> o <i>nly</i> one) ne 5√2 Residence	6 ∏Other (Spe	cify)
Division of	Attending Physician: It death. ector: After this certific by the funeral director.	Certification:	27. Manner of Death 12 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	2	28d. Describe how in		
-	2 = 5		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)			28f. Location (Street City or Town, St	ate)	
	ਵ .⊆ ਵ ਰ	edicai	29a. Certifier (Check only one) Certifying Physical Examination	cian: To the best of my knowledge, de er: On the basis of examination and/or and manner stated.	ath occurred at the time, da investigation, in my opinior	ate and place, a n, death occurre	and due to the cause ad at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	or with	Σ	29b. Signature and title of certifier	A.	29c. License nun D003329		29d.	Date signed (Month	h, Day, Year)
1			30. Name and address of person who com		e, Print)			1	
	Stat		31. Date filed (Month, Day, Year)	th 5454 Wisconsin 32. Registrar's Signature	Ave. Chevy C	hase, M	ID 20815		
	Registra	ır	MAR 2 3 2006	Marie St. 19					

nysici	ian	Decedent's Name (First, Middle, La							Date of Deal Month	h Day	Year	3. Time of	f Death
Medi	cal	Dorothy		Allen	45 65	T	1		March		006	7:20	A
xamir	ier	4a. Facility Name (If not institution, giv			4b. City,	_	Location o	Death		4c. County			
neral		Summerville Assis	Sex 7. Ag	e (In yrs. last birthda)	y) If Under	1 Year	omac If Under 2		8. Date of Birth	Mont			or Fore
ector		233 -18-2497	I□M 2XF	79 Yrs.	Months	Days	Hours	Min.	Nov. 7,	1926	I1	place (State ontry) linois	3
**		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	Location		~					10d. Inside C	ity Lim
fieds	호	Maryland Montgom	ery		Potoma	.c					ŀ	1 ሺ Yes	2 🗌
He de	Directo	10e. Street and Number			10f. Zip				1	0g. Citizen of V	Vhat Cou	intry?	
untra	ai	11215 Seven Locks	s Rd.			20	854			U.S.	Α.		
E E	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	l. Was Deced	dent of Hi	spanic Orig	gin? (Spec , Puerto P	cify Yes or No- lican, etc.)		e - Ameri k, White,	can Indian, , etc.	
뒬	by Fu	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 f If Yes, Give Year or Dates:	40	1 🗆 Yes		Specify:				Whi		
G IE	ed	15. Decedent's E		16a. Dec	edent's Usua	ai Occupa	ation			16b. Kind of Bu			
Med	piet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5	(Giv	O NOT us	rk done d se retired,	<i>duri</i> ng most ')	of workin	g			,	
2	Completed	Liononary, Social ary (V 12)	5+		Socia	L Wor	rker			Healt1	n Car	re	
Vent	Be (17. Father's Name (First, Middle, Last,)				18. Mothe	r's Name	(First, Middle, I	Maiden Sumam	e)		
ratic	2	Albert Phillips						raila					
any injury or other traumatic avant, it a Medical Examiner must be notified at once.	3	19a. Informant's Name/Relationship (Phillip Allen/Nep	•						Route Number				
ther	1 3	20a. Method of Disposition		20b. Place of Disp						20c. Location -			
0 0		1 🗆 Burial 2 🗶 Cremation 3 🗆		cemetery, cri	ematory`or o		e) Ma	arch 2006			·		
injur)		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Lifer		1	Crema	tory	s of Facility		l Funei	Alexand		Virgi	.nı
onc			7.0		LZ. Namo an	222	22 Wi	scons	D.C. 20	An N. W.	_		
		23a. Part1. Enter the disease, or com	plications that caused	the death. Do not e	nter the mod							Approximat	
cian		shock, or heart failure. List only immediate Cause (Final		_{ne.} atic Carci	noma							Interval Bet Onset and	
dical		disease or condition resulting in death)	a	a consequence of):	.IIOliia								
iner			Cholang										- 1
ij	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as	a consequence of):									
trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c										
the burial-transit	0	resulting in cealiny Last	Due to (or as	a consequence of):									
thet	dlcal		_ d							<u> </u>	-		
for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy						23d. Date	e of delia	100	
1 for u	ciar	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pr ☐ Other (sp					Mor			Year
achec	nysi	1 ☐ Yes 2 ♣ No 9 ☐ Unknown	9□ Unknown			,, <u> </u>							
be detached f	by P	Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying c	ause give	n in Part I.		23e. Did tob	acco use contr	ibute to t	the cause of c	death
D									1 □ Ye	s 2 🕅 No	3 ☐ Prot	babiy 4 □l	Jnkn
2	Completed								24a. Was a autops		Vere auto	opsy findings empletion of c	avail
2 should	E								perform	ned? d	leath?	2 □ No	ause
	Be	25. Was case referred to medical examiner?					26. Place	of Death	Check only on				
		1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatie					sing Hom	e 5 🗆 Reside	nce 6X1Othe	er (Specii	h)Asst.	Li
director, page 2	P	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da)	ry y Year) 28b. Time Injury		8c. Injury Work			8d. Describe ho	w injury occurre	вd		
al director, page 2		2 Accident investigation		115	М		res 2□N		04		0	10	
funeral director, page 2		2	200. Place of Inj	ury - At home, farm, s c. <i>(Specify)</i>	treet, factory	, опісе		20	8f. Location (St. City or Town		er or Hura	ал ноцю мит	1007,
in by the funeral director, page 2		2 - 100130111	building, etc					d place as	nd due to the co	use/s) and ma	oner as s	etated	
in by the funeral director, page 2	Certification:	3 Suicide 6 Could not b 4 Homicide determined	building, etc	of my knowledge, dea	ath occurred	at the tim	e date and						
in by the funeral director, page 2	Certification:	3 Suicide 4 Homicide 6 Could not b determined	building, etc nysician: To the best niner: On the basis of and manner sta	f examination and/or i	ath occurred investigation,	at the tim in my op	e, date and pinion, deat	h occurre	d at the time, da	ate and place, a	ind due t	o the cause(s	i)
in by the funeral director, page 2		3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only 2 Medical Exar	building, etc nysician: To the best niner: On the basis of	f examination and/or i	nvestigation,	at the tim in my op License	oinion, deat	h occurred	d at the time, da	ate and place, a	ind due t	o the cause(s	s)
funeral director, page 2	edical Certification:	3 Suicide 4 Homicide Check only one) 3 Suicide 4 Could not be determined Could not be determined Could not be determined Could not be determined	building, etc nysician: To the best niner: On the basis of	f examination and/or i	nvestigation,	in my op	oinion, deat number	h occurred	d at the time, da	ate and place, a	ind due to	o the cause(s	s)
in by the funeral director, page 2	edical Certification:	3 Suicide 4 Homicide Could not be determined 29a. Certifier (Check only one) Could not be determined	building, etc nysician: To the best niner: On the basis of and manner sta	f examination and/or i ated.	29c I	License	oinion, deat o number L096	h occurred	d at the time, da	ate and place, and place and place and place signed arch 27,	ind due to	o the cause(s	5)

		e Hegistrar	State of I	Maryla		artmen <i>rtificat</i>			Mental Hy	/giene	000		1)93	39
Physic		1. Decedent's Name (First, Middle, Las M★RIE B	,						2. Date of Di Month MACC	Da		(ear	3. Time of	
/Medi Exami		4a. Facility Name (If not institution, give	street and number		AL		Town, or	Location of De		4c	County of	Death		
Funerat Director		5. Social Security Number 6. Sec. 195-07-9122	7	Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 24 H Hours Mi		av. Year)		Count	ace (State of try) SYLVAN	
within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show the Madical Exertities must be notified at	ector	10a. State 10b. County MARYLAND MONTGOM 10e. Street and Number	ERY	10c. C	ity, Town or Lo	LLVER		ING		10.00			Od, Inside Cit	
death with ns 23s or	Funeral Director	2921 NORTH LEISUR	12. Was Decede	nt Ever in I		10f. Zip	20	0906	(Specify Yes or N	UI	NITED 14. Race -	STA	TES	
rel', or iter	ρ	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Diverced	Armed Force 1 ☐ Yes 2 ☐ If Yes, Give Year or Date:	s? MNo		If Yes, spec 1 ☐ Yes		n, Mexican, Pue	(Specify Yes or Nearto Rican, etc.)			White, e		
within 72 h iene. r than "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 1 1	cation le completed) College (1-4c	or 5+)	16a. Dece (Give life.	kind of wo DO NOT us	rk done d se retired,	furing most of w	rorking		ind of Busin		·	
should be filed ind Mental Hygis marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) WILLIAM J. HIRTLE	Y						ame (First, Middle IA TEM)	, Maiden		510		
is 1 and 2 sho of Health and Item 27 is m other traum		19a. Informant's Name/Relationship (7) WILLIAM N. BRINSO	•	205		18TH	RD.		ARLING	CON,	VA 22	2205		
permit. Pages Department of Important: If Ite any njury or of		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens		TR	Cometery, creating INITY N	natory or o IEM . (ther place GDNS .	27	ARCH 2006	WA	LDORI	F, M	wn, State ARYLAN	ID
Depo Impo		23a. Part1. Enter the disease, or comp	Hour	J	I	0.BC	OX 15	6, WALI	HUNTT FUN DORF, MAR	RYLAN		504	Approximate	
Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each a	ATU as a conse	quence of):	Pro	us						Interval Betwoonset and D	veen
certificate be executed by the continuate be executed by the contract of the certificate by the certificate	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	YELD as a conse	DYSPV quence of):	1s Tic	- 541	UDROM	E				HONTY	13
death e atter id for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fet	aldeath 3□	Ectopic pro					23d. Date o Month			'ear
equires that en signed b ould be deta	þ	Part II. Dther significant conditions co	ntributing to death			nderlying ca	ause give	n in Part I.		Yes 2		ute to the	cause of de	eath?
The la ate has page 2	Completed										prio	r to com	sy findings a ipletion of ca 2 \(\text{No} \)	variable use of
/sicial s certification	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	tient 2	ER/Outpatien	t 3 🗆 DO	Othe		eath Check only of Home 5 ☐ Resi		© □Other	/C		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	ertification: T	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		28b. Time of Injury		8c. Injury Work		28d. Describe			эр в сту)		
pital or Att urs after d sral Direct illed in by t	O	3 Suicide 6 Could not be determined		etc. (Speci	ity) 				28f. Location (City or To	wn, State))er,
the Hosi hin 24 ho the Funt npletely f	Medical	29a. Certifier 1 × Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis and manner:	of examina	ation and/or inv	estigation,	in my op	inion, death occ	e, and due to the curred at the time,	date and	place, and	due to	the cause(s)	
To Too	~	29b. Signature and title of certifier	HOLPIT	ALIST	Γ		License				e signed (A		•	
DO 18		30. Name and address of person who consumed the summer of	mpleted cause of	PHN	m 23a) (Type, EPH7L	Print)	JUE	, DLNE	MARYL	AND	205	232	/	
Sta Registr		31. Date filed (Month, Day, Year) MAR 2, 4	J2. 1 gis	trar's Sign	ature	mark.	,							

State of Maryland / Department of Health and Mental Hygiene 1961 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year Berkman 8:06 A 17, March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery | Honder 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Hours | Min. | 3-22-1923 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Director 577-22-5801 82 Michigan Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show rai', or items 23a or 28a-f shov Examinar must be notified at Yes 2 No MD Montgomery Bethesda Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6441 Rock Forest Drive #102 death U.S.A. 20817 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If Item 27 is marked other then "natural", or iter
Iry or other traumatic event, Ite Mudicul Examinat 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 δ 1 Yes 2 No Specify: Specify:White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary U.S. Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Berkman ဂ္ Epstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) crtant: If Item 27 is Betty E. Berkman-Sister 6441 Rock Forest Drive #102 Bethesda, MD 20817 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State njury 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Falls Church, VA 3-20-2006 permit.
Dep. rtn
Imp.crts
any nju 21. Signature of Funeral Service Licensee Baltzansky Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Arteriosclerosis 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o. as a consequence of). Examine physician and s the burial-transit certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as attending use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 Other (specify) P.O. the detached 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by diabetes mellitus 1 ☐ Yes 2 🏝 No 3 Probably 4 □Unknown hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy hyperlipidemia performed? of Vital 1 Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3 DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Attending 1 X Natural 5 Pending Injury death. Director: 2 Accident investigation 1 ☐ Yes 2 ☐ No in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after of To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D12121 3-18-06 f person who completed cause Sengstack 3929 f death (Item 23a) (Type, Print) Ferrara Drive Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32 degistrar's Signature State 2006 Registrar

			State of Maryla	-	rtificate of			g. No.	()	0941
	Physician	1. Decedent's Name (First, Middle, Last, Herbert Bus		JC \			2. Date of Death Month Macch	Day	Year	3. Time of Death 2220
1	/Medical Examiner	4a Fecility Name (If not institution, give				4b. City, Town, or Lo	ocation of Death	4c. County		
7	Examiner	BROOKE GROVE REHABIL	HATION AND NO	JRSNG C	ENTER	ANDY SPE	21NG	MONT	LOMI	ERY
	Funeral Director	5. Social Security Number 6. Sec	7. Age (In y	rs. last birthday, 87 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, AUGUST 27			ce (State or Foreign y) HUSETTS
	lend	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation				100	d. Inside City Limits
	Many to to	MARYLAND MONTGOMERY	ROC	KVILLE						1 ☐ Yes 2 🖾 No
	or 286-f or positions	10e. Street and Number			10f. Zip Code		10	Og. Citizen of V	Vhat Countr	y?
	h with	17008 FREEDOM WAY			20853			U.S.A.		
20	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mertal Hydiene. Depertment of Health and Mertal Hydiene. Important: If them 27 is marked other than "natural" or thems 23e or 28e-f show eny Injury or other treumetic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 1∄Yes 2 □ No If Yes, Give Year or Dates: 194		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🖾 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes <i>o</i> r No- Rican, etc.)		e - Americai k, White, et	c.
Maryland 21215-0020	uld be filed within 72 hours a Meral Hygiane. Inted other than 'natural', o site event, the Medical Exer To Be Completed by	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Bu	usiness/Indu	stry
2121	d within giene.	Elementary/Secondary (0-12)	College (1-4or 5+)	MANAGE				PRUDENTIA		RANCE
nd	al Hy Vent	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	<i>laiden Sumam</i>	ne)	
yla	Ment Ment arked atic	GEORGE W. COLBURN				MYRTLE BUS				
Jar	2 sh end is m	19a. Informant's Name/Relationship (T)				and Number or Rur			State, Zip C	ode)
esî	lend Health m 27 her t	CONSTANCE WILSON/DAUGHT			FREEDOM WAS osition (Name of	, ROCKVILLE		20853 20c. Location -	City or Tow	n. State
Baltimore,	Pages nent of h	1 ☑ Burial 2 ☐ Cremation 3 ☑ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cre	matory or other pla CEMETERY			HOLYOKE,	•	
Balti	permit. Depertrimporta eny Inju	21. Signature of Funeral Service Licens	Judoux	H		ess <i>o</i> f Facility DI FUNERAL H AMPSHIRE AVE		P SPRING	MARV	I AND 20904
		23a. Part1. Enter the disease, of comp	ications that caused the							Approximate ntervel Between
	Physician /Medical Examiner	shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death)	CEREBRO	VASCU o (or as a conse		CIDENT			1	Onset and Death
68760,	tificate be executed g physician and as the buriel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a conse						
Box	h cert endin r use		d					w terr		
	deat of fo	Part II. Other significent conditions con	ntributing to death but not	resulting in the	underlying cause gi	ven in Part I.	23b. Did to	becco use co	ntribute to	the ceuse of deeth?
, D.O.	that the ned by the detech	SENILE DEME	NTIA				1 🗆 Y	s 2□No	3 ☐ Probe	abiy 4 Unknown
Vital Records,	The law requires that the death certificate has been signed by the attending page 2 should be deteched for use a Completed by Physician/Me						24a. Was a perform		avai	re autopsy findings lable prior to ipletion of cause eath?
Re	The la ate has page 2						1 □ Ye	s 2 No	10	Yes 2□ No
ta	certificate rector, pag	25. Was case referred to medical				26. Place of Dea	th (Check only on	e.l	100	
<u>></u>	Physician: this certific ral director,	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatie	ent 3 DOA Ot	her: 4X Nursing Ho	ome 5□Reside	nce 6 □Oth	er (Specify)	
Division of	To the Hospital or Attending Physician: within 24 hours eiter death. To the Funeral Director: After this certification properties of the funeral director, completely filled in by the funeral director, Medical Certification: To Be (27. Manner of Death Natural 5 Pending Call Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury	Wo	ryet rk?]Yes 2 □ No	28d. Describe ho	ow injury occur	red	
Divis	tal or Attending Programmers effer death. al Director: After the din by the funera certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, s ec <i>ify)</i>	treet, factory, office		28f. Location (St City or Town		er or Rural	Route Number,
	ne Hospital no 24 hours ne Funeral pletely filled edical C	(Check only one) 2 Medical Exami	ner: On the best of my and manner stated.	knowledge, dea nination and/or i	th occurred at the t nvestigation, in my	me, date and place, opinion, death occur	and due to the cored at the time, d	ause(s) end ma ate and place,	anner as sta and due to	ated. the cause(s)
	within To the comple	29b. Signature and title of certifier				se number		9d. Date signe		
) Con	TENDINA O	HUCKLE	DU CH	12046	M	VARCH "	22. 2	206
,	5-1	30. Name an inddress of person who c	ompleted cause of death	(Item 23a) (Type	, Print)					20860
_		GRACE BROOKE HUFFA	Mr. 40- 181	100 SLA	DE SCHO	OL KOAD	SANDY	Sprinc	TMA	RYLAND
	State Registrar	31. Date filed (Month, Day, Year) MAR 2 4 200	7. Registrar's S	ignature	and I		,			

Decedency Name (First, Middle, Last) TACOMA CLARK CLORY Town, or Location of Death MARCH 19, 2006 7:15A M AFACHY NAME (First, Middle, Last) TACOMA CLARK County of Death MARCH 19, 2006 7:15A M AFACHY NAME (First, Middle, Last) Tacomic Name (First, Middle, Middle) Tacomic Name (First, Middle, Last) Tacomic Name (First, Middle, Last) Tacomic Name (First, Middle, Middle) Tacomic Name (First, Middle, Last) Tacomic Name (First, Middle, Middle) Tacomic Name (First, Middle, Middle) Tacomic Name (First, Middle, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic Name (First, Middle) Tacomic				For State Registrar	State of I	Maryland /			nt of H te of L			lental H	ygien Reg. N	21111	6	10942
TACOMA CLARK CLARK CLORY Town of Location of Death Rob City To					st)									\a	V	3. Time of Death
## Country of Death Hebrew Home of Greater Wash Foreign Country	1			TACOMA	CLA	RK										7:15A M
Hebrew Home of Greater Wash Rockville Rockville Rockville Rockville Rockwille	7							4b. City	, Town, or	Location	of Death					
Source State 10 10 10 10 10 10 10 1				Hebrew Home of	Greate	r Wash		R	ockv	ille	9			Mont	gome	ry
Dec. 18, 1918 Alabama The finding of property Top Copy T		Funeral		5. Social Security Number 6.	Sex 7.						Min.	(Month, L	Day, Yea	(r)	9. Birthpl	ace (State or Foreign
The second of th				106-05-3611	1 □ M 2 💢 F	87	Yrs.	MONITA	Days	Tiodis	141.11	Dec.1	8,1	918	Ala	.bama
The property of the property o		D.				10a Cibi Te		antina							11	2d Incida City Limite
The property of the property o		anylar show	_	10a. State 10b. County		Toc. City, 10	DWII OF LC	cation								
To a second process of the second process of		80-f	cto		mery	Si	lvei									
The property of the property o		ith th	Dire	10e. Street and Number				10f. Z								try?
The property of the property o		ath w 23s	ral	3662 Edelmar	7										<u> </u>	
The property of the property o		teme	une		Armed Force	is?	13.	Was Dece If Yes, spe	edent of Hi ecify Cuba	spanic Ori n, Mexicar	rigin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	10-			
The property of the property o	36	s efte	γFi		If Yes, Give			1 🗆 Yes	2 No	Specify:	•			Specify:	Bl	ack
To a second process of the second process of	8	hour urel	d b		1		Sa Dago	dont's He	ial Occupa	tion			16h	Kind of Bu	einaee/lna	luetny
The property of the property o	5	n 72	lete	(Specify only highest gi	ade completed)		(Give	kind of w	ork done d	lurina mos	st of worki	ing	100.	King of Du	3111033/1110	lustry
To a second process of the second process of	2	withis	ш		College (1-4								D	riva	+6	
The property of the property o	2 2	Hygid ther	ပိ		")		DOOI	reeb	CT_	18. Mothe	er's Name	e (First, Middi				
The property of the property o	ä	od be	Be							Ві	irdi	e ?				
Physician Middled Examiner The proposed and the proposed anamed and the proposed and the proposed and the proposed and the p	Ž	d Me d Me mark matk	Ĕ			_ 1	9b. Mailie	ng Addres	s (Street a					or Town.	State, Zip	Code)
Physician Middled Examiner The proposed and the proposed anamed and the proposed and the proposed and the proposed and the p	S	d2s than 71e.		Jana Woods-Je	fferson	nd-										
Physician Middled Examiner The proposed and the proposed anamed and the proposed and the proposed and the proposed and the p		1 an Healt em 2 ther				20b. Place	of Dispo	sition (Na	me of	1			7			
Physician Middled Examiner The proposed and the proposed anamed and the proposed and the proposed and the proposed and the p	፩	1 2 2 3 B		1 Burial 2 Cremation 3		ite	-	,	,		າ /າ າ	106	7	lova	ndri	D 577
Physician Middled Examiner The proposed and the proposed anamed and the proposed and the proposed and the proposed and the p	≣	Frank Park				Met										•
Physician Middled Examiner The proposed and the proposed anamed and the proposed and the proposed and the proposed and the p	Ba	Depe mpo mpo nny lr		21. Signature of Furieral Service Lice	L Va.	man V	/									
Physician Medical Examiner of obath) The condition resulting in obath but not resulting in the underlying cause given in Part I. The condition resulting in obath but not resulting in the underlying cause given in Part I. The condition resulting in obath but not resulting in the underlying cause given in Part I. The condition resulting in obath but not resulting in the underlying cause given in Part I. The condition resulting in obath but not resulting in the underlying cause given in Part I. The condition resulting in obath but not resulting in the underlying cause given in Part I. The condition resulting in obath but not resulting in the underlying cause given in Part I. The condition resulting in obath but not resulting in the underlying cause given in Part I. The condition resulting in obath but not resulting in the underlying cause given in Part I. The condition re		20200		Solling Sold Sold Sold Sold Sold Sold Sold Sold	1000	Wee for the	-							CILVI	110,	
Due to (or as a consequence of): COTONATY ATTERY DISEASE Due to (or as a consequence of): COTONA												эт төзрпатогу	arrost,			Interval Between
Due to (or as a consequence of): COONDAY Artery Disease Due to (or as a consequence of): Due to (or as a	ä			disease or condition	a			ial	Infa	rct	lon					
Countingly late nordinary at the first Underlying and the immediate gause. Einer Underlying against a first underlying against a				resulting in death)				B	·							
Due to (or as a consequence of): Due to (or as a consequence of):	П	LAGITITICI	_	Sequentially list conditions	b			cy n	ısea	ise			_		-	
Due to (or as a consequence of): Due to (or as a consequence of):		sit ad	lne	if any, leading to immediate cause. Enter Underlying	of euc	as a consequent	ce or):									
Section Sect		ecute and tran	Саш	that initiated events	C. Due to (or	26.2 CONSOCUON	oo of):									
FFEMALE: 23d. Date of delivery 23d. Date of deli	9	oe ex cien	<u> </u>	,	Due to (or	as a consequent	Ja 01).									
FFEMALE: 18	87	cate t	dlca	•	d											
State Stat	9 ×	entific ding p	Me	IF FEMALE:	220 If was autom	mo al programan				111				00 (0-1)	-1 4-1 -	
State Stat	Ô	ath o	lan/		1 Live birth	1 2 ☐ Fetal dea	ath 3[•
State Stat	<u>-</u>	the a	sic	1 ☐ Yes 2X No			1 5L	J Other (s	респу)							
State Stat	<u>.</u>	d by	F.		contributing to deat	h but not resultin	a in the u	nderhina	cance dive	en in Part I	1	23e Dio	i tobacce	use contr	bute to th	e cause of death?
State Stat	Ś	res ti	þ	Tarrii. Othor significant contactors	continuously to doub	i bat not rodanii	9		oddoo girt	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	••					
State Stat	Ö	requi	ted													
State Stat	Ö	as b	현									aut	ODSV	D	rior to cor	osy lindings available npletion of cause of
State Stat	<u>~</u>	The ate h page	ĕ									per 1 ☐ Yes	Tormed? 2 ☐	No 1	eath? ☐ Yes	2 ℃ No
State Stat	<u> </u>	stan: ertific ctor,	3e (26. Place	e of Deatl	h Check only	(eno			
State Stat	<u>_</u>	nysic nis ce	2		1 🗆 Inp		Outpatier		UA	4 [_P[V]	ursing Ho	me 5□Re	sidence	6 □Othe	r (Specify)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thuan Nguyen, MD Kaiser Permanete Silver Spring Medical Center 31. Date filled (Month, Day, Year) 32. Registrar's Signature	0	ng PI	ü		28a. Date of I (Month,	njury 281 Day Year)		f	28c. Injury Work	at c?		28d. Describe	e how in	jury occurre	ed	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thuan Nguyen, MD Kaiser Permanete Silver Spring Medical Center 31. Date filled (Month, Day, Year) 32. Registrar's Signature	<u>ত</u>	endlr path. pr: Al	atle	2 Accident investigation	on			М	1 🗆 '	Yes 2]No					
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thuan Nguyen, MD Kaiser Permanete Silver Spring Medical Center 31. Date filled (Month, Day, Year) 32. Registrar's Signature	ž	r Att	‡	dotormino	289. Place of	Injury - At home etc. (Specify)	, farm, sti	eet, facto	ry, office						r or Rura	l Route Number,
D044883 March 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thuan Nguyen, MD Kaiser Permanete Silver Spring Medical Center State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ā	talo Isaft al Di	Cer													
D044883 March 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thuan Nguyen, MD Kaiser Permanete Silver Spring Medical Center State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		lospl hour uner														
D044883 March 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thuan Nguyen, MD Kaiser Permanete Silver Spring Medical Center State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		the H in 24 he F plete	edi	one)	and manner	stated.	anayor ill				000011	tura (alli				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thuan Nguyen, MD Kaiser Permanete Silver Spring Medical Center State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To t To t	Σ	29b. Signature and title of certifier			M	2	9c. License	number					•	
Thuan Nguyen, MD Kaiser Permanete Silver Spring Medical Center State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		5		In	Va		111		D044	1883			M	larch	24,	2006
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		_		30. Name and address of person who											_	
	_			Thuan Nguye	n, MD F	Kaiser				Silve	er S	pring	y Me	dica	1 C∈	enter
					0000	A Section	A	mule	9							

Physician /Medical Examiner

Funeral Director

MARYLAND M 10e. Street and Number 318	CHOI stitution, give OSPITAL 6. Se 1 dent County ONTGOMER Married ivorced ecedent's Ed y highest gran (0-12)	a street and number of the street and number o	Age (In yrs.) 78 10c. City ent Ever in U. es?	Yrs. y, Town or Lo KENSIN	SILVER If Under 1 Year Months Days	Hours Min.	Month MARCH 19 8. Date of Birth (Month, Day JANUARY	4c. Cor MON' Year) 3, 192	Co	hplace (State untry) REA 10d. Inside (
HOLY CROSS H S. Social Security Number NA Usual Residence of Dece- 10a. State MARYLAND MARYLAND MORYLAND MORY	OSPITAL 6. Se 1 dent County ONTGOMER Married ivorced ecedent's Ed y highest grad (0-12)	Court 12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date ucation de completed)	Age (In yrs.) 78 10c. City ent Ever in U. es?	Yrs. y, Town or Lo KENSIN	SILVER If Under 1 Year Months Days coation IGTON 10f. Zip Code 2089	SPRING If Under 24 Hrs. Hours Min.	JANUARY	MON' Year) 3, 192	TGOMERY 9. Bird Co 8 KO	hplace (State untry) REA 10d. Inside (City Limits
NA Usual Residence of Deceitor Na Usual Residence of Deceitor Na Usual Residence of Deceitor Na Na Na Na Na Na Na Na Na Na Na Na Na N	6. Se 1 dent County ONTGOMER COUNTY ONTGOMER COUNTY ONTGOMER COUNTY ONTGOMER ON	Court 12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date ucation de completed)	10c. City 10c. City ent. Ever in U. es?	Yrs. y, Town or Lo KENSIN	If Under 1 Year Months Days cocation IGTON 10f. Zip Code 2089 Was Decedent of H	If Under 24 Hrs. Hours Min.	JANUARY	Year) 3, 192	9. Birtl <i>Co</i> 8 KO	hplace (State unity) PREA 10d. Inside (City Limits
NA Usual Residence of Deceitor Na Usual Residence of Deceitor Na Usual Residence of Deceitor Na Na Na Na Na Na Na Na Na Na Na Na Na N	6. Se 1 dent County ONTGOMER COUNTY ONTGOMER COUNTY ONTGOMER COUNTY ONTGOMER ON	Court 12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date ucation de completed)	10c. City 10c. City ent. Ever in U. es?	Yrs. y, Town or Lo KENSIN	months Days coation IGTON 10f. Zip Code 2089 Was Decedent of F	Hours Min.	JANUARY	3, 192	8 K0	PREA	City Limits
Joe Street and Number 10 Never Married 2 Never	dent County ONTGOMER Married ivorced ecedent's Ed y highest grad (0-12)	Court 12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date (ucation de completed)	10c. City ent Ever in U. es? □XNo	y, Town or Lo KENSIN	Docation IGTON 10f. Zip Code 2089 Was Decedent of H		JANUARY	3, 192	8 KO	REA	
10b. MARYLAND M 10c. Street and Number 12 Control Number 12 Control Number 13 Control Number 14 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 15 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 16 Control Number 17 Control Number 17 Control Number 17 Control Number 18 Contr	ONTGOMER ONTGOMER Married ivorced ecedent's Ed y highest grav (0-12)	12. Was Deceded Armed Force 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ent Ever in U. es? DXNo	KENSIN	IGTON 10f. Zip Code 2089 Was Decedent of H	95	1	0g. Citizen	of What Co	1 □ Ye	
MARYLAND M 10e. Street and Number 11. Marital Status 1 Never Married 2 3 Widowed 4 D (Specify on) Elementary/Secondary 6	ONTGOMER ONTGOMER Married ivorced ecedent's Ed y highest gran (0-12)	12. Was Deceded Armed Force 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ent Ever in U. es? DXNo	KENSIN	IGTON 10f. Zip Code 2089 Was Decedent of H	95	1	0g. Citizen	of What Co	1 □ Ye	
10.e. Street and Number 31.0 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Married ivorced ecedent's Ed y highest grad (0-12)	12. Was Deceded Armed Force 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	es? DXNo	S. 13.	10f. Zip Code 2089 Was Decedent of H	95	1	0g. Citizen	of What Co	untar?	
11. Marital Status 1 Never Married 2 3 Widowed 4 D (Specify on) Elementary/Secondary	Married ivorced ecedent's Ed y highest grad (0-12)	12. Was Deceded Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date ucation de completed)	es? DXNo		2089 Was Decedent of H	95		og. Citizeri	OI WITH CO		
1 Never Married 2 3 Widowed 4 D 15. D (Specify on/ Elementary/Secondary	ecedent's Ed y highest grad (0-12)	Armed Forc 1 Yes 2 If Yes, Give Year or Date ucation de completed)	es? DXNo		Was Decedent of H			KOR	EA	or itry i	
3 🖾 Widowed 4 🗆 D 15. D (Specify on) Elementary/Secondary 6	ecedent's Ed y highest grad (0-12)	1 Tes 2 If Yes, Give Year or Date ucation de completed)	□XNo		ii 165, Specify Cubi	hispanic Origin? (Spi	ecify Yes or No-		Race - Ame Black, White	rican Indian,	
15. D (Specify on) Elementary/Secondary 6	ecedent's Ed y highest grad (0-12)	Year or Date ucation de completed)			1 ☐ Yes 2 ☒ No		riodii, oto./		acihe:		
(Specify only Elementary/Secondary 6	y highest grad (0-12)	de completed)			103 223140	Specify.		3,0	AS	IAN	
Elementary/Secondary 6	(0-12)			(Give	dent's Usual Occup	during most of work	ing	16b. Kind	of Business/	Industry	
	Middle, Last)	College (1-4	lor 5+)	life.	DO NOT use retired	d)		01111	ПОМЕ		
17. Father's Name (First,	Middle, Last)			HOME	MAKER				HOME		
						18. Mother's Name	e (First, Middle,	Maiden Sui	mame)		
UNKNOWN						UNKNOW	N				
19a. Informant's Name/R	elationship (7	ype, Print)		19b. Maili	ng Address (Street	and Number or Run	I Route Number	, City or To	own, State, Z	Zip Code)	
DONG RHEE - G	RANDSON			-		RT; KENSINGI					
0a. Method of Disposition 1 ☐ Burial 2 ☐ Cree		Removal from St	C	lace of Dispo emetery, cre	osition (Name of matory or other plac		Date	20c. Locat	ion - City or	Town, State	
4 Donation 5 C				LINCOL	N CREMATORY	Y 3/24/	2006	BRENT	WOOD, M	D	_
21. Signature of Funeral	Service Licen	see		2	2. Name and Addre	ess of Facility HIN	ES-RINALD	I FUNE	RAL HOM	E	
Myeli	Till	lobest		1	.1800 NEW HA	AMPSHIRE AVE	; SILVER	SPRING	MD 209	04	
23a. Part 1. Enter the disc shock, or heart failu	ease, or comp	olications that cau	used the death	h. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximation and Interval Be	etween
Immediate Cause (Final	io. List only			CIC CARE	IOVASCULAR	DISEASE				Onset and YEARS	Death
disease or condition resulting in death)	-	a. Due to (or	r as a consequ	uence of):							
Sequentially list condition f any, leading to immedia cause. Enter Underlying	is, ite	Due to (or	r as a consequ	uence of):							
Cause (Disease or injury that initiated events	1	c									
resulting in death) Last	- 1	Due to (or	r as a consequ	uence of):							
		d									
IF FEMALE: 23b. Was decedent pregr	nant	23c. If yes, outco	ome of pregna		☐Ectopic pregnanc	v		23d	. Date of del	-	
n the past 12 month 1 ☐ Yes 2 X No	ns?	4 Pregnar	nt at time of de		Other (specify)				Month	Day	Year
9 Unknown		9 Unknow	vn								
Part II. Other significant	conditions o	ontributing to dea	th but not resi	ulting in the u	inderlying cause gr	ven in Part I.	23e. Did to	bacco use	contribute to	the cause of	death?
OVARIAN CA	NCER						1 □ Y	es 2 🗆 N	lo 3∏Pr	obably 4 2	Unknown
CEREBRO VA	SCULAR A	ACCIDENT					24a. Was a	n 2	4b. Were au	utopsy finding	s available
							autop: perfor	med?	death?	utopsy finding completion of	cause of
25. Was case referred to	modical					OC Disco of Door	1 Yes		1 🗌 Yes	2(X) No	
examiner?	medical	Hospital:	X	ER/Outpatie	- all Box Ott	26. Place of Deat			701h-1 (C-1	n/4 /)	
1 Yes 2 No	1	28a. Date of		28b. Time of	III 3 DOX	4 Norsing Fig	me 5 Resid			Ciry)	
1 Natural 5 □	Pending investigation	(Month,	Day Year)	Injury	Wo	rk?]Yes 2 ☐ No					
2 Accident 3 Suicide 6	Could not be		d Injuny - At he	ome farm st	reet, factory, office		28f. Location (S	treet and N	lumber or Ru	ural Route Nu	mber.
4 🗍 Homicide	determined	building	g, etc. (Specify	y)	, .uctory, onice		City or Tow				
(Check only 2 🗌 🖡			is of examina			me, date and place, opinion, death occur					(s)
one) 29b. Signature and title o	f certifier	and manne	stateu.		29c. Licens	se number		9d. Date s	igned (Mont	h, Day, Year)	
230. Signature and title of	10	Q IM	001x	1118	D0062				9/2006		

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) MAR 2 4

32. Rigistrar's Signature

2006

Book!

State Registrar

MAR 2 4 31. Date filed (Month, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

PAUL ARMSTRONG, M.D.

14201 LAUREL PARK DRIVE, SUITE #102, LAUREL, MARYLAND 32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

4323

29d. Date signed (Month, Day, Year)

23,2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** March 21, 2006 10:30A William Leonard Catterton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Civista Medical Center La Plata Charles If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 1**X** M 2 ☐ F 7. Age (In yrs. last birthday). 61 Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Months 06-21-1944 217-42-0493 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director Md. Waldorf Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20603 11045 Berry Road USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/industry College (1-4or 5+) Elementary/Secondary (0-12) 11 Locksmith Owner/ operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Catherine Marie Rawlings Crumpton Earle Catterton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Ie m eny Injury or other traum once. 11045 Berry Road Waldorf, Maryland, 20603 B of Disposition (Name of Date 20c. Location - City or Town, State Vonna B. Catterton 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03-25-2006 Waldorf, Md. Trinity Mem. Gardens 22. Name and Address of FacilityHuntt Funeral Home 21. Signature of Funeral Service License MUDDOD Stotram 3035 Old Washington Rd. Waldorf, Md. 20604 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as gardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): IF FEMALE

Physician /Medical Examiner

Funeral

Director

Item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at

12 should be filed within 7. h and Mental Hygiene. 7 Is marked other then "ni

Baltimore,

Physician/Medical

the attending physicien and hed for use as the burial-transit detached for ð Completed certificate has Be 2 this Hospital or Attending Pl
 Hours after death.
 Funeral Director: After the Certification:

Division of Vital Records, P.O. Box 68760

certificate be

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

20 No

examine

1 Yes

27. Manger of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

cai

State

Registrar

4 | Homicide

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Year Day

3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

TN

3 DOA

24a. Was an autopsy

1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 Yes 202 No 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify)

2 No

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 Could not be

29c. License number

D-37174

29d, Date signed (Month, Day, Year) 0

P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Song C. Chon, MD Cenna Medical Center 7C Post Office Rd Waldorf, MD 20602 32. Registrar's Signature

MAR 2 4 2006

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

DHMH 17 Rev 1/2001

24 hours

To the I within 2. To the B

			1 - For State Registrar	•	epartment of Health and I	Mental Hygie	ene 0 0 6	0946
			Hegistrar Decedent's Name (First, Middle, Last			2. Date of Death		3. Time of Death
	Physicia		Margaret Ann			Month March	Day Year 31, 2006	4:15 P M
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
	Examin	Ei	Oakland Nursing &		0akland		Garre	tt
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last birthe		8. Date of Birth (Month, Day, Y	9. Birth	nplace (State or Foreign untry)
	Director		215-66-4280	□M 2対F 48 Yr	s. Months Days Hours Will.	Apr11 30,	1957 Ind	iana
	ը _		Usual Residence of Decedent	to- City T-	-1			10d. Inside City Limits
	show	Ļ	10a. State 10b. County	10c. City, Town o	Location			1 Tes 28 No
	Ba-f	5	MD Garre	tt	0akland	10-	J. Citizen of What Co	
	vith th	Funeral Director	10e. Street and Number		10f. Zip Code	log		
	s 23s	rai	1500 Boiling Spri		21550	pecify Yes or No-	USA 14. Race - Amer	
	item Item	un.	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	o Rican, etc.)	Black, White	
36	Ir, or	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:	White
9	within 72 hours after death with the Maryland ene. ttan "neturel", or llems 23e or 28e-f show ts M. ofcell Examinet must be notified at	ed	15. Decedent's Ed	ucation 16a. D	ecedent's Usual Occupation	16	6b. Kind of Business/	ndustry
215	hin 7.	pie	(Specify only highest grad	College (1-4or 5+)	Give kind of work done during most of wor ife. DO NOT use retired)	Kirig		
21215-0036	d with	Completed	12th		ealth Care Worker		Social Se	rvices
pu	al Hy I othe vant	Be (17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma		
/lai	Ment Ment wrked write	2	Joseph	Cowgill	Virgin			hnson
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat, or items 23a or 28a-f show any njury or other traumatic event, It's Modeal Examinat must be notified at ance.		19a. Informant's Name/Relationship (7)		Mailing Address (Street and Number or Ru			
	and ealth n 27	. 1	William Cowgill,		00 Boiling Spring I		cland, Md.	
Baltimore,	of Hi of Hi if itan		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	Disposition (Name of crematory or other place)		c. Location - City or	rown, State
Ē	Pag ment ant: ury c		`4 ☐ Donation 5 ☐ Other (Specify	Omega	OI CHECOLY .	and the same of th	lorgantown	
att	permit Depart Import any inj once.		21. Signature of Funeral Service Licent)	22. Name and Address of Facility	_	S. Second	
ш	20129	01.00.00	VStall NY	and	Stewart Funeral Ho		cland, Md.	
			23a. Part1. Enter the diseas, or comp shock, or heart failure. List only of	lications that caused the death. Do no one cause on each line.	t enter the mode of dying, such as cardia	c or respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Cirrhosis of t	he Liver			years
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
	LAGITITIET	L	Sequentially list conditions,	bAlcoholism				years
	ad sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)-			
	and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
760,	be executed ician and burial-transit	cal E			·			
687	e y s			d				
× 6	certifica nding ph use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnancy			23d. Date of del	ivery
Вох	atten for u	ian	in the past 12 months?	1☐Live birth 2☐Fetal death 4☐Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
P.O.	the di	ysic	1 □ Yes 2 🔼 No 9 □ Unknown	9□ Unknown				
	that the de ned by the a detached f	Y P	Part II. Other significant conditions of	ontributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds	8 5 0	d by				1 ☐ Yes	2 ⊠ No 3 □ Pr	obably 4 Unknown
00	- Q to	ete				24a. Was an	24b. Were au	itopsy findings available
Records,	The law ate has page 2 :	Completed				autopsy	ed? death?	completion of cause of 2 ☐ No
Vital	uiclan: Th certificate rector, pag	e Co	25. Was case referred to medical		26 Place of De	1 ☐ Yes 2 ath (Check only one)		2 140
Ξ	Physician: this certific ral director,	00	avaminar?	Hospital: 1 Inpatient 2 ER/Outp	Other	***	ce 6 ☐Other (Spe	cifv)
of		7: To	27. Manner of Death	28a. Date of Injury 28b. Ti	ne of 28c. Injury at	28d. Describe how		,,
Division	Attanding Ph r death. actor: Atter th by the funeral	tiol	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		ury Work? M 1 ☐ Yes 2 ☐ No			
/isi	Attandi r death actor: A	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree	eet and Number or Ru	ural Route Number,
D	To the Hospital or Attanowithin 24 hours after death To the Funeral Director:	Certification:	4 Homicide	building, etc. (Specify)		Only of Young	Jiatoy	
	spita hours mera y fille	ai	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge,	death occurred at the time, date and plac	e, and due to the cau	use(s) and manner as	s stated.
	n 24 na Fu	Medical	(Check only 2 Medical Examone)	and manner stated.	or investigation, in my opinion, death occ			
	To the within To the Comp	Σ	29b. Signature and title of certifier	0 0 00	29c. License number	29	d. Date signed (Mont	
			1 Paris	el Miller	H26154		3/31/20	006
	=		30. Name and address of person who		ype, Print)			
_	5		P. Daniel Mille		cres Drive, Oakland	d, Md. 215	50	
		ate	31. Date filed (Month, Day, Year) APR - 4 2	32. Registrar's Signature	Locals 2			

NLM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 23a,27,0en/E, (854,4/12/06 TI State of Maryland / Department of Health and Mental Hygiene 06-02249 For State Registrar John Dattoli Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** John Michael Dattoli 2006 7:58 A April /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth April Day, Year 1958 Birthplace (State or Foreign Country)
 New York If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** Months **№** M 2 F 47 100-56-5982 Yrs. Director Usual Residence of Decedent 10d. fnside City Limits 10c. City. Town or Location 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1 TYes 25000 Silver Spring Maryland Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number items 23a or 20902 USA 12008 Bernard Drive death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Maritaf Status 1 ☐ Never Married 2 Harried Specify: White ō 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 δ 3 Widowed 4 Divorced 'neturei' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Colfege (1-4or 5+) Efementary/Secondary (0-12) Federal Government Engineer other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked other eny injury or other traumatic event ADRs. Be Florrie D'Arco John Dattoli ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12008 Bernard Drive, Silver Spring, MD 20902 19a. Informant's Name/Relationship (Type, Print Mary E. Dattoli/ Wif Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition April 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2006 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) a Atherosclerotic cardiovascular disease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dua to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 MUnknown 1 ☐ Yes 2 ☐ No peed 24b. Were autopsy findings available prior to completion of cause of d→1 h?
1 A Yes 2□ No 24a Was an autopsy performed? certificate 1X Yes 2□No ours efter death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check only one) Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 XER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred fnfury 5 Pending 1 Tes investigation 2 ☐ Accident 6 Could not be 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide within 24 hours e To the Funeral Completely filled To the Hospitei 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier April 2, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) In in 1NG 111 Penn Street Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 04 2006 09461 Registrar

	1 = For State Registrar	State of Maryland /	Department of Health Certificate of Death	ו ר	Reg. No. 106 1948
Physician /Medical Examiner	Decedent's Name (First, Middle, Last) CHARLES JOSHUA 4a. Fecility Name (If not institution, give s		4b. City, Town, or Location	2. Date of Dea Month 6 3	Day Year 23 06 0540 M
Funeral Director	5. Social Security Number 6. Sex	7. Age (In yrs. last) 65	oirthday) If Under 1 Year I II Under 1 Year Months Days Hours	Min. 8. Date of Bird (Month, Da. FEB 22,	1941 BALTIMORE, MD
Maryland 1-f ahow Ited at	10a. State 10b. County DELAWARE SUSSEX		wn or Location LSBORO		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
outer death with the Mauritems 23s or 28s-1 sidiler must be notified of Funeral Director	10e. Street and Number 36091 LYNCH ROAD		10f. Zip Code 19966		10g. Citizen of What Country? UNITED STATES
by Br.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 🕱 No Specify		14. Race - American Indian, Black, White, etc. Specify: WHITE
ed within 72 hou ygiene. The than "natura than "natura than "catura than completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		ia. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) MECHANIC	ost of working	16b. Kind of Business/Industry CONSTRUCTION
Marylatic 2 12. 4 2 should be filed within th and Mental Hygiene. 77 is marked other than traumatic avent, the Mr. To Be Comp	17. Father's Name (First, Middle, Last) GEORGE THOMAS		I	her's Name (First, Middle, LETTIE ROGE)	RS
INGIY	19a. Informant's Name/Relationship (Ty) SUE E. DAVIS		9b. Mailing Address (Street and Num 36091 LYNCH ROAL	ber or Rural Route Number MILLSBORG	
Dallillole; bermit. Pages 1 a Department of Hes mportant: if Itam any injury or otha ance.	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	of Disposition (Name of tery, crematory or other place) SBORO CEMETERY	Date MAR 28,2006	20c. Location - City or Town, State MILLSBORO, DE
permit. Pages 1 and 2 Department of Health a Important: If Itam 27 is any Injury or other tre once.	21. Signature of Funeral Service License	99	22. Name and Address of Fac WATSON FUNERA MILLSBORO DI	L HOME	
anth certificate be executed anth certificate be executed settlending physician and for use as the burial-transit cruse es the burial-transit	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	be cause on each line. Small Due to (or as a consequence of the consequence)	Cell Lun W Met		rrest, Approximate Interval Between Onset and Death
Attanding Physician: The law requires that the death certifical releases.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delivery Month Day Year
w requires that been signed be should be deta	Part II. Other significant conditions cor	4 .	g in the underlying cause given in Pal	•••	obacco use contribute to the cause of death? Yes 2 □ No 3 ☑ Probably 4 □Unknown
vital neck sician: The law rector, page 2 sh rector, page 2 sh			Ge Die	24a. Was auto perfo 1 Yes ace of Death (Check only	psy prior to completion of cause of death? 2 ☑ No 1 ☐ Yes 2 ☑ No
n Of Vitaling Physician og Physician ter this certifineral director on; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	lospital: 1 Tinpatient 2 ER/ 28a. Date of Injury (Month, Day Year) 28	Outpatient 3 DOA Other: 4 Dob. Time of Injury at Work?	Nursing Home 5 Resi	dence 6 □Other (Specify) how injury occurred
DIVISION OF VITAL RECORDS, To the Hospital or Attending Physicien: The law requires t within 24 hours effer death. To the Funeral Director: Affer this certificate has been signe completely filled in by the funeral director, page 2 should be o Medical Certification; To Be Completed by	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	M 1 ☐ Yes 2 , farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, wn, State)
o tha Hospital or thin 24 hours afte the Funeral Dir mpletely filled in Medical Cert	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death occurred at the time, date and/or investigation, in my opinion, d	and place, and due to the leath occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier	Doglen	29c. License number	283	29d. Date signed (Month, Day, Year) 3 - 24 - 2006
77	30. Name and address of person who co		a) (Type, Print) WOLL ST. SUITE	A-1 Solish	un, mD 21801

Amended Item 31 per Carroll County 03/27/2006 wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedept's Name (First, Middle, Last) = 30 P ESAI **Physician** ASUMATI 06 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore 8 Reisterstown Watch Ct. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1□ M 2∏F 88 Yrs 217-45-2179 02/19/1918 India Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-1 ehow Examiner must be notified at 1 ☐ Yes 2 █ No Director Reisterstown MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 ітетя 23а 21136 USA Funeral 8 Watch Court 13. Was Decedenl of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married "naturel", or 1 ☐ Yes 2 ☐ No Specify: Asian Indian þ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry The Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled wire Department of Health and Mental Hygien Important: if item 27 is marked other the eny injury or other traumatic event, Inc. once. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Champaklaxmi Oza ည Chaganlal Bakshi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 8 Watch Ct. Reisterstown, MD 21136 Yoqesh Desai Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 #☐ Cremation 3 ☐ Removal from State Carroll Cremation 03/24/06 Hampstead, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21074 21. Signature of Funeral Service Licensee teven 934 South Main Street Hampstead, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiac /Medical Due to (or as a consequence of) Examiner Eonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-transit and Due to (or as a consequence of) ettending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Felal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No deteched 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 2 **N**0 3 Probably 4 Unknown 1 Tes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Back aches 24a. Was an autopsy performed? certificate has 1 ☐ Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one, 25. Was case referred to medical examiner? funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🛣 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No M death 2 Accident investigation within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifie (Check only

WJL 3

To the Hospital or Attending Physicien: The lew requires that the death certificate be executed

Division of Vital Records.

P.O. Box 68760.

death

filled within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wag & Swelth m: D - 42/2 32. Registrar's Signature

W)

Rd. Westminster Md. 21157

29d. Date signed (Month, Day, Year)

29c. License number D 2 2 6 6 3

hysich

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** рм 2006 Cynthia March 20, 8:05 Holloman /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Takoma Park Montgomery Sligo Creek Nursing & Rehab. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 282 M Jan. 15, 1925 Director 81 143-20-4266 New Jersey Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 le marked other than "natural", or items 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20903 9150 Piney Branch Road, #204 USA Completed by Funeral iled within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Beautician Hair Styling 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Richard Lee Essie Wilson မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20903 19a. Informant's Name/Relationship (Type, Print) Billy Dah/ Husband 9150 Piney Branch Road, #204, Silver Spring, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marchite 25, 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 6 2006 Metropolitan Crematory Alexandria, Virginia 4 □Donation 5 Other (Specify) any injury Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring MD 20901 21. Signature of Faneral Service Acense Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final **Physician** Few Years Colon Cancer with Metastasis to Liver and Lung disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the for use as attending IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 90 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 又Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physicien: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes P 2**∑** № this 28c. Injury at Work? funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Certification: or Attending 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital TXXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

State Registrar

32 Registrar's Signature 31. Date filed (Month, Day, Year) MAR 2 3 2006

MKon MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mobarak Karim, M.D. 7610 Carroll Aven

D18895

7610 Carroll Avenue, #340, Takoma Park, MD 20912

March 21, 2006

0

			4 277	partment of Health and Mental Hy	/giene Reg No. 0 0 6 1 0 9 5 1
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Denise Marie Drew	2. Date of D Month March	eath 3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital	4b. City, Town, or Location of Death Clinton	4c. County of Death Prince Georges
	Funeral Director		5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 V F 7. Age (In yrs. last birthda, 5. 2 Yrs. Usual Residence of Decedent	Months Days Hours Min. (Month, D	th ay, Year) 9. Birthplace (State or Foreign Country) 20,1953 Wash., DC
	Maryland	tor	10a. State		10d. Inside City Limits 15€ Yes 2 ☐ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 4282 7th Street, SE #204	10f. Zip Code 20032	10g. Citizen of What Country? United States
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 le marked other than "natural", or items 23 or 28e-f ehow other traumatic event, fre Medical Exeminations to multiled at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 3 Z No If Yes Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:	
Maryland 21215-0036	within 72 ho ene. than "natur re Medical	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) acher Aide	16b. Kind of Business/Industry DC Public Schools
and 2	ild be filed lental Hygi ked other ic event, Il	To Be Co	17. Father's Name (First, Middle, Last) William Horns	18. Mother's Name (First, Middle	
	1 and 2 should Health and Men em 27 le marke wher traumatic	-	19a. Informant's Name/Relationship (Type, Print) Lorie A. Drew Gordon/daughter	ling Address (Street and Number or Rural Route Numb 1215 Kenwood Rd. Glen Burnie, MD 21	per, City or Town, State, Zip Code)
Baltimore,	Pages 1 at ment of Hea ant: If item ury or othe		TAX DUTAL 2 COMMANDI 3 CHARLOVALITORI STATE	position (Name of Park Place) Mem. Park 4/7/06	20c. Location - City or Town, State Landover, MD
Balt	permit. Pages Department of Important: If i any injury or o		Janua Edward 3	22. Name and Address of Facility Hodges (Suitland, MD. 20746
	Physician /Medical		231. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Intrindiate Cause (Final disease or condition resulting in death)		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	egfic lenkoming	unknown
3/60, <	cate be executed hysician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C		
. Box 68	attending p	Physician/Medl		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
as, P.O.	w requires that the de been signed by the should be detached	þ	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the		obacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ⊅ nknown
vital Records,	0 5 0	Completed		24a. Was auto perfic	an 24b. Were autopsy findings available prior to completion of cause of death?
	certifi rector	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check only of the state	one)
DIVISION OF	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification: T	27. Manner of Death 1	TO DOX 4 TOTAL SING TIONE 3 Nest	dence 6 Other (Specify) how injury occurred
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certifi	4 Homicide determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	City or To	
	the Hos hin 24 ho the Fund mpletely f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or is and manner stated.	ivestigation, in my opinion, death occurred at the time,	date and place, and due to the cause(s)
		_	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type RowTAN FAR Affi FAR M.D. 980) 31. Date filed (Month, Day, Year) APR 0 7 2006 32. Segistrar's Signature	29c. License number D 4 3 446	29d. Date signed (Month, Day, Year)
	1,2		30. Name and address of person who completed cause of death (Item 23a) (Type ROINTAN FAR AHI FAR M.D 980)	Georgia Ausnit 3-41 Silv	u Sprig 10 20902
	Sta Registra	e ar	APR 0 7 2006 32. Registrar's Signature	and a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Men	tal Hygiene
Certificate of Death	Reg. No.

Division of Vital Records, P.O. Box 68760,

	uı.		1_ For State	State of Marylar		artment of H		Mental Hy	giene 006	10952
λ.			Registrar 1. Decedent's Name (First, Middle.	l ast)	Cel	illicale of t	Dealli	2. Date of De	Reg. No.	3. Time of Death
	Physici			rl Woodward Embr	20.14			March 2	Day Year	
)	/Medic		4a. Facility Name (If not institution,		еу	4b. City, Town, or	Location of Dea		4c. County of Deat	9:17 P M
	CAGITIII	101		n Medical Center	_		shington		Prince G	
	Funeral			6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt	th 9. Birt	nplace (State or Foreign untry)
	Director		579-22-4409	1□M 2XIF 89	Yrs.	Months Days	110012 IVIII	April 1	[8, 1916 Kei	ntucky
and	3		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
Maryl	6 B	ō	Maryland Prince			Washingto	n			1 ☐ Yes 2X No
the	28e	rec	10e. Street and Number	acorge 3	1 6. 1	10f. Zip Code	TI .		10g. Citizen of Whal Co	untry?
h with	23a o at be	ai D	10924 Riverview	Road			20744		USA	ŕ
deat	ma (Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No	- 14. Race - Ame Black, White	
afte a	or It	by Fu	1 ☐ Never Married 2 ☐ Marrie	ed 1 ∐ Yes 2 X ☐ No If Yes, Give		1 ☐ Yes 2 🕱 No	Specify:	to thour, oto.,	Specify:	White
Pour S	al Ex	d b	3 XWidowed 4 □ Divorced	Year or Dates:	16a D	danila Marria Oran				
in 72	n "na Aadic	Completed	15. Decedent' (Specify only highest	grade completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of wo	orking	16b. Kind of Business/	industry
with A	r the	l mo	Elementary/Secondary (0-12)	College (1-4or 5+)		unch Oper			US Gove	ernment.
3 8	al Hyg	Bec	17. Father's Name (First, Middle, L	ast)				me (First, Middle,	Maiden Sumame)	
y la	and Mental Hygiene. Is marked other then "natural", or Items 23a or 28e-f ehow aumatic event, the Madical Examinar must be mutified at	Tof	John W. Woodward				Mat	tie Love	lace	
2 sho	le m		19a. Informant's Name/Relationsh						er, City or Town, State, Z	ip Code)
and a	fealth im 27 her ti		Woodward C. Embr			Ramsey Co	urt, Sal			
Pages	Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28e-f ehow any Injury or other traumatic event, the Madical Examiner qual be nutified at QDEs.		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation	3 □Removal from State	cemetery, crer	natory`or other place	·	Date	20c. Location - City or	
it Pg	intmer intent njury		4 □Donation 5 □ Other (Sp 21. Signature of Funeral Service L		1	Cemete Name and Addres			Suitland, M	
permit	Depa Impol any Ir		Mark M.	M00053		intt Fune			old Washingt 6, Waldorf,	
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused the dear	th. Do not ent	er the mode of dying	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between
	ysician		Immediate Cause (Final disease or condition	a. Hypertensive at	hemsolo	mbe cand	Laura Saul	ar dispos	0	Onset and Death
	Medical aminer		resulting in death)	Due to (or as a consec	quence of):		· D C C S C C C C C C C C C C C C C C C C			
		-E	Sequentially list conditions if any leading to immediate	b. Due to (or as a consec	uence of):					
petr	insit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540 (5 (5. 45 4 55.155)	100 1100 017.					
cate be executed	physicien and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consec	quence of):					
ite be	ysicie he bu	dical		d						
	00 60	Med	IF FEMALE:		_					- Ip-
ath ce	attending i	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta	aldeath 3 [Ectopic pregnancy			23d. Date of deli Month	very Day Year
Attending Physician: The law requires that the death certifi	ned by the attendin detached for use	Physician/Me	1 ☐ Yes 2 Ø No 9 ☐ Uriknown	4☐ Pregnant at time of c	death 5□	Other (specify)			World	Day rear
thatt	ed by detac		Part II. Other significant condition	s contributing to death but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute lo	the cause of death?
uires	70.00	d by	Amal fibrillation	dements						bably 4 Unknown
§ × 0	s been signated by should b	Completed						24a. Was	an 24h Were au	opsy findings available
The la	age 2	mo						autop perfor	rmed? prior to death?	ompletion of cause of
an:	is certificate has director, page 2	0	25. Was case referred to medical				26. Place of Dea	1 Yes ath Check only o		2 □ No
ysic	direct	To B	examiner? 1 √ 2 Yes 2 ☐ No	Hospital: 1 Inpatient 2 x	ER/Outpatien	t 3 DOA Othe		77	lence 6 □Other (Spec	ify)
5 E	After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			low injury occurred	
tendi	tor: A	cati	2 Accident investiga 3 Suicide 6 Could no	ation of the			res 2 □ No			
or A	Direc Direc I in by	Certification	4 Homicide determin		ome, farm, stre fy)	eet, factory, office		28f. Location (S City or Tow	Street and Number or Ru m, State)	ral Route Number,
ospita	within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of my kno xaminer: On the basis of examina	owledge, death	occurred at the tim	e, date and place	e, and due to the	cause(s) and manner as	stated.
the H	thin 24	Medical	one) 29b. Signature and title of certifier	and manner stated.	and and or my	29c. License				
1	8 ₹ 8		-/4. 1 0 M	port un				1	Mossob 22	
0			30. Name and address of person w	ho completed cause of death (Iter	n 23a) (Tyne	OCME			March 22, 2	2000
T	BIA		Taska 2 Green	sens M.D	cou, (rype, I		Street,	, Baltimo	ore, Marylar	nd 21201
	Sta		31. Date filed (Month, Day, Year)	32. Pojistrar's Signa	ature				<u> </u>	
	Registra	ar	MAR 2	4 2006 Mesers.	J. B	DENE S				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mildred Virginia March 30°, 2006° Flick 11:13 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Moran Manor Nursing Home Westernport Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 12 1 216-05-9612 94 Director 1912 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location Items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at MD. Allegany Westernport Director 1 ☐ Yes 2√ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21562 25801 Shady Lane, Apt. 324 United States death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes No Specify: white 2 3√Widowed 4 ☐ Divorced "neturel", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker unknown Pages 1 and 2 should be filed inent of Health and Mental Hygismut: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John E. Cheshire Elsie Riggleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is eny injury or other treu once. J. Thomas Cheshire/son 119 McKinley St, Westernport, Maryland 21562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/01/ Philos Cemetery Westernport, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, 21562 Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arainma U /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, but any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Miknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an millotas has autopsy certificate 1 Yes Division of Vital To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: ٩ 1 Tes 2 No Marsing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA After thi funeral 27. Manner of Peath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Natural 5 Pending investigation death. 1 🗌 Yes I Director: / 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland 21532 Dr. Jesus Tan, 4 Broadway St., Frostburg 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR Registrar

			1 - For State Registrar AMEND#10cperFH3	State of Ma				nt of H te of L				giene Reg. No	and the	0	10954
	af.		Decedent's Name (First, Middle, Last)	21,00,111	<i>,</i> 1000						2. Date of De.	ath			3. Time of Death
ı	Physici		Ethel Gibson								Month March	Da 21		Year O.G	8:00P M
4	/Medic Examir		4a. Facility Name (If not institution, give st				4b. City, Town, or Location of Death 4c. County of						O:UUP		
			Clinton Nursing an	d Rehab.	Cent	er	C1:	Clinton					ince	Geo	rges
	Funeral		Social Security Number 6. Sex	7. Ag	e (In yrs. la	ast birthday)	If Unde	or 1 Year Oays	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da	h V Year		9. Birthp	place (State or Foreign
	Director		376-01-3039	M 2Å F	96	Yrs.	WOTHING	Oays	riours	IVIII.	Sept. 2	25,1	7 909		inia
	pud *		Usual Residence of Decedent 10a. State 10b. County		10c City	, Town or Lo	cation							· 1	lod leside City Links
	daryis aho	ŏ	,		For	ct Wasl	ning:	ton						'	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
	28a-1	Director	MD Prince Ge	orges	0001	Bock		p Code				10- 0			
	with a or	ā	6801 Bock Road Apt	427				744				U.S	tizen of Wi	nat Cour	ntry ?
	hours after death with the Maryland lural', or items 23a or 28a-f ahow al Exacti ar must be notified at	Funeral		. Was Decedent	Ever in U.S	S. 13 V	1	· ·	spanic Orio	nin? (Spe	cify Yes or No.			- Americ	can Indian.
_	r Her	듄	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2XX					n, Mexican	, Puerto F	cify Yes or No- Rican, etc.)			, White,	etc.
3	al', o	ρ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	I □ Yes	2 No	Specify:				Specify:	RT.	ack
215-0036	72 ho	Completed	15. Decedent's Educa (Specify only highest grade			16a. Deced	lent's Usi	al Occupa	tion uring most	t of working		16b. K	ind of Bus	iness/In	dustry
V	thin.	npie	Elementary/Secondary (0-12)	Coltege (1-4or 5	i+)	life. L	DO NOT	se retired)	uning most	OI WOIKII	'y				
7	ed w ygjer yer th	ပို		1		Nuı	rse	,					pital		
/land	d dath	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
<u>Ş</u>	ould Men varke vatic	9	Richard Henry Shor								. A. Le				
ğ	12 sh h and 7 Is n		19a. Informant's Name/Relationship (Type	,							Route Numbe				•
e O	1 and Healt		JoAnne Moore/ Niec 20a. Method of Disposition	e	20h Pl	ace of Dispos			TTS D		rt Wash		COD M.		
ਠੁ	2 = 2 = 2		1 ☑ Burial 2 ☐ Cremation 32 ☐ Ren	moval from State	ce	emetery, crem	natory or	other place	·					-	
Saitimore	it. Pi		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Cli	fton (/25/:	2006 es Fune		fton,		
מ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f ahow myning yor other traumatic event, the Musical Exacting mermual be notified at once.		12 00 1								assas,			-	ne.
			23a. Part1. Enter the disease, or complica	tions that caused	the death								2011		Approximate
	- 22		shock, or heart failure. List only one trmediate Cause (Final	cause on each iir	16.							1651,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Atheros			ardio	vasci	ılar	Disea	ase				5 years
	Examiner			Oue to (or as	a consequ	ence or):									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as	à consequ	anca of).		_						-	
	uted d ansit	Examin	Cause (Disease or injury that initiated events												
Š	exec en an rial-tr		resulting in death) Last	Due to (or as	a consequ	ence of):									
8/00,	ficate be executed physicien and s the burial-transit	cai	d.												
0	ng ph ng ph as tl	Medi	IF FEMALE:									- 1			
X O	death certiff e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome 1□Live birth			Ectopic p	regnancy					23d. Date		•
	e dea	sici	1 ☐ Yes 200No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	time of dea		Other (s						Mont	h	Day Year
Ċ	d by letach			business death bu		hiith			: D 41		00 - Dida				
GŠ,	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Ď	Part II. Other significant conditions contr	buting to death bi	ut not resul	iting in the un	ideriying	cause give	n in Part I.						ne cause of death?
	requ hould	etec									101	95 2			ably 4 🔀 Unknown
Lecor	has b	Completed									24a. Was autop	Sy	24b. We	or to cor	psy findings available npletion of cause of
2	cate										perfor 1 ☐ Yes	meo? 2∑kNo		ath? Yes	2 □ No
<u> </u>	ician certif recto	Be	25. Was case referred to medical examiner?	spital:				Othe		of Death	Check only or	ne		-	
5	Phys raidi	2	1 ☐ Yes 2 🔀 No	1 ☐ Inpatie 28a. Date of Injur		R/Outpatient 28b. Time of		JA	4X JQ vui		e 5 Resid				1)
5	ding h. After fune	ţ	1 ⊠Natural 5 ☐ Pending	(Month, Day	Year)	Injury	м	28c. Injury Work'	ai ? es 2∐N		8d. Describe h	iow injur	y occurred	1	
VISION	Atten deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ırv - At hon	ne. farm. stre					Bf. Location (S	Street an	d Number	or Rura	l Route Number,
Ś	after after 1 Dire	Certification:	4 ☐ Homicide determined	building, etc	(Specify))	. sty rubtol	31 UNIO			City or Tow	n, State)	s. riura	
	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2.		29a. Certifier 1	ian: To the best of	of my know	vledge, death	occurrec	at the time	e, date and	d place, ar	nd due to the d	ause(s)	and manr	ner as st	ated.
	n 24 n 24 ne Fu	edicai	(Check only 2 Medical Examine one)	 On the basis of and manner sta 	examination	on and/or inv	estigation	, in my op	nion, deati	h occurre	d at the time, o	date and	place, an	d due to	the cause(s)
	To th within To th comp	M	29b. Signature and title of certifier				29	c. License	number		ž	29d. Dat	e signed (Month,	Day, Year)
1	2		M & de		. /	1.0		745	365			Маз	ch 2	2. 2	2006
4	0		30. Name and address of per on who com	pleted cause of de	eath (Item :	23a) (Type, F	Print)			-			4	-, 4	
			MICHEAL SIDARIONS 1	1701 Liv	ingst	ton Rd	. #10	01 Fo	rt Wa	shin	gton, N	/dd	20744	' +	
	Sta Registr	_	31. Date filed (Month, Pay, Year) MAR 2 4 200	32. Registra		ure	and a	,							
	11491511	:10	200	O Base	12 A 14	/ AND THE STATE OF THE STATE O	STATE OF THE PARTY								

		1 - For State Registrar	State of Mary			nt of H	ealth ar		ental Hyg		106	09	55
Physic		Decedent's Name (First, Middle, Last Homero Andres							2 Date of Dea Month March	Day	Year	3. Time of	f Death a M
/Medi Exami		4a. Facility Name (If not institution, give	,				Location of Spring		march .	4c. Cc	ounty of Dea Iontgo		
Funeral Director		5. Social Security Number 6. S 465 – 38 – 4009 1 Usual Residence of Decedent	TXW alle	yrs. last birthday) 74 Yrs.	If Unde Months	1 Year Days	If Under 24 Hours	Min.	8. Date of Birth (Month, Day Jan • 14	, Year 93	9. Bin	thplace (State of buntry) exas	r Foreigr
72 hours after death with the Maryland "natural", or Items 23s or 28s-f ahow cilcal Examiner must be notified at	Funeral Director	10a. State 10b. County Maryland Montgon 10e. Street and Number		c. City, Town or Lo					10g. Citizen of What (10d. Inside Ci	
s 23s or	eral Di	13221 Rippling F			2	0906					USA		
ours after de	by	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:				spanic Origir n, Mexican, F Specify: M		ofy Yes or No- ican, etc.)		Race - Ame Black, Whit ecify.Whi		
C	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		kind of wo DO NOT u	rk done d se retired,	uring most o		7		of Business/		
A SE SE SE SE SE SE SE SE SE SE SE SE SE	To Be Co	17. Father's Name (First, Middle, Last) Andres E. Guerra	5+	Elec	trica	1 En	Engineer Engineer Engineer 18. Mother's Name (First, Middle, Maide Guadalupe Alvare			Maiden Su			
and 2 should the salth and Menter to 27 is marked in traumatic.		19a. Informant's Name/Relationship (7 Frances Guerra/	,, , ,						Route Number Drive,			Zip Code) ring, M	D209
permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other traumatic o		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Onation 5 Other (Specify	Temovar Hom State	Ob. Place of Dispo cemetery, crem Metropolit				arc¶ 200			ion-City or idria,	Town, State Virgin	ia
permit. Departr Importa		21. Signature of Funeral Service Licen	See See	F. 50	ranci 00 Un	gAdges iver	coilly sity B	ns I	Tuneral W, Si	Home lver	Inc Sprin	g MD 20	901
death certificate be executed Wedical Examiner A for use as the burial-transit	icai Examiner	23a. Part. Anter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, I sauring to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor Due to (or as a cor	of Unknothing of the office of								Approximate Interval Beto Onset and D 1 Yea	ween Death
death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pr				-311 	23d.	Date of deli Month	,	'ear
es tha	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the ur	nderlying ca	ause give	n in Part I.			acco use o		the cause of de	
The ate h	e Completed	25. Was case referred to medical						_	24a. Was ar autops perform 1 Yes 2	/	death?	topsy findings a completion of ca 2 \(\text{No} \)	ivailable
Phys this al dir	ToB	examiner?	28a. Date of Injury	1 Inpatient 2 EH/Outpatient				ng Home	Check only one Reside d. Describe ho	nce 6		erfy)	
2055	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, stre	eet, factory	, office		28	28t. Location (Street and Number or Rural Route Num City or Town, State)				20 <i>1</i> ,
To the Hospital of within 24 hours af To the Funaral D completely filled in	Medical	one)	sicien: To the best of my ner. On the basis of exar and manner stated.	knowledge, death nination and/or inv	occurred a estigation,	at the time in my opi	n date and p	lace, and	d due to the ca at the time, da	use(s) and te and pla	I manner as ce, and due	stated. to the cause(s)	
To t To t	Σ	29b. Signature and title of certifier	yen		290	License D233			58		-	, <i>Day, Year)</i> , 2006	
		30. Name and address of person who co Victor Priego, MI		ltem 23a) (Type, F edge Dri	ve, #	4100	, Beth	esda	a, MD 2	0817			
Sta Registr		31. Date filed (Month, Day, Year) MAR 2 3 20	32 Registrar's S	ignature	We)						-		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

2 Date of Death

Nonth

Bood

DR Robert Welik

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32. Registrar's Signature

Githens

PITA

1 Decedent's Name (First, Middle, Last)

Mae

4a. Facility Name (If not institution, give street and number)

JORED HOURT

Betty

Physician

/Medical

Examiner

3 Time of Death

1103

10d. Inside City Limits

21562

Approximate Interval Between Onset and Death

Yes 2 No

9. Birthplace (State or Foreign

West Virginia

County of Death

10g, Citizen of What Country?

16b. Kind of Business/Industry

Grocery Store

20c Location - City or Town, State

23d. Date of delivery

29d. Date signed (Month, Day, Year)

MARCH 31, 2006

Day

2 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Year

Month

2 **P** No

Cumberland, Maryland

14. Race - American Indian, Black, White, etc.

white

United States

Year) 1918

ALLEGAN

DHMH 17 Rev 1/2001

State

Registrar

400 Seton Drive Cumbercans

	-		Please	Type or Prin	nt in Black	Indelible In	k. Ensure	All Copies	Are Legible.	
			1 - For State Registrar	State of Ma		epartment of Certificate of	f Health and of Death	-	giene	10957
*	Physici		Decedent's Name (First, Middle, La HARRISON		AY			2. Date of De Month		
	/Medio		4a. Facility Name (If not institution, given			4b. City, Town	n, or Location of Deat		4c. County of De	
	i .	J.	Washington Ad	ventist 1	Hospital	L Ta	akoma Pai	rk	MONTGO	OMERY
as _{rox}	Funeral Director		5. Social Security Number 6. 5 78-07-2921		e (In yrs. last birthd 96 Yrs	ay) If Under 1 Ye	ar If Under 24 Hrs	8. Date of Bir (Month, Da	th Q B	irthplace (State or Foreign Country) Maryland
	pur *		Usual Residence of Decedent . 10a. State 10b. County		10c. City, Town o	Location				101 (
	e Maryis la-f sho	ctor	MD Montg	omery		Rockvill	.e			10d. Inside City Limits 1 Yes 2 No
	or 26	Oire	10e, Street and Number			10f. Zip Code	е		10g. Citizen of What C	Country?
	23a	rai	616 N. Horne	rs Lane		2	20850		U.S.A.	•
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-1 show any injury go other traumatic event, the Medical Eventual Instituted at once.	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ∑Yes 2 □ N If Yes, Give Year or Dates:	Ever in U.S. 42-47	3. Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.)	,	
21215-0036	hin 72 ho s. na "natura Medical I	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(G	ecedent's Usual Occ ive kind of work do e. DO NOT use ret	cupation ne during most of wo ired)	rking	16b. Kind of Busines	s/industry
21	d wit	mo:	Elomoniary Goodingary (o 12)	2 yrs		Parts D	river		Centur	y Ford
밀	al Hy I oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	, Maiden Sumame)	
/la	Ment Ment arked arice	2	Jessie Harri	day			El	izabet:	h	
Maryland	2 sho and is mu	0.0	19a. Informant's Name/Relationship (**					er, City or Town, State,	
≥ .	and ealth n 27		Margaret H. F	razier (N	liec∈)			Lane,	Rockville	, MD 20850
ore	of H		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery,	sposition (Name of crematory or other p	olace)	Date	20c. Location - City o	r Town, State
Ë	Pag ment ment		4 ☐ Donation 5 ☐ Other (Special	(x) 1	Lincol		Cem 3-2		Rockvill	•
Baltimore,	permit. Depart Import any inj once.		21. Synatur Himeral Service Lo	Show	Den				FUNERAL H kville, M	OME, P.A. ID 20850
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not	enter the mode of d	tying, such as cardia	c or respiratory ar	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Constitution	20101					Onset and Death
18.	/Medical		resulting in death)	Due to (or as	a consequence of):					
100	Examiner			· ~0~	mintel.	Mailes	01			
	70	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Sue to (or as	consequence of):	1 Jan W	1			
	be executed ician and burial-transit	Examiner	that initiated events	a Sa	coal d	ecubil	T.			
60,	be exe ician a burial-1		resulting in death) Last	•	a consequence of):		4/4			
		Icai		a Allele	Only	and l	erral La	stone		
687	ng pl	Med	IF FEMALE:							
.O. Box	The law requires that the death certificate Lite has been signed by the attending physic bage 2 should be detached for use as the b	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal death	3 ⊟Ectopic pregnar 5 □ Other (<i>specify</i>)			23d. Date of de Month	elive <i>r</i> y Day Year
ם ַ	that led b	P.	Part II. Other significant conditions of	contributing to death bu	it not resulting in th	a underlying cause	given in Part I.	23e. Did to	bacco use contribute t	to the cause of death?
Records,	w requires been sign should be	Ω							/es 2 □ No 3 □ P	
		Completed						24a. Was autop perfor 1 \(\text{Yes} \)	sv prior to	utopsy lindings available completion of cause of s
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					ath (Check only o	ne)	
	hys this	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatie		ient 3L DOA			tence 6 □Other (Spe	ecify)
uo O	ing After une	tion:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Time Injur	y W	jury at /ork? □ Yes 2 □ No	28d. Describe h	now injury occurred	
É	or Atten ifter deal Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ry - At home, farm, . (Specify)	street, factory, offic		281. Location (S City or Tow	Street and Number or R rn, State)	iural Route Number,
	o the Hospital ithin 24 hours a to the Funeral I ompletely filled	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best on niner: On the basis of and manner sta	examination and/or	eath occurred at the investigation, in my	time, date and place y opinion, death occu	, and due to the d irred at the time, d	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	ro the H vithin 24 ro the Fi complete	Me	29b. Signature and title of certifier	NA-		29c. Lice	nse number		29d. Date signed (Mon	th, Day, Year)

Division of Vital Records, P.O. Box 68760,

Part II. C	Other significant conditions	contributing to death t	out not resulting in the	a underlying cause	given in Part I

24a.	Was	an
	auto	
	nort	ormed?
	Poil	uninga:

	aut	opsy formed?
	1 ☐ Yes	2 No
10	back only	one)

26. Pla	ce of Death (C	heck only	one)	
4 🗆 1	Nursing Home	5 🗆 Res	sidence 6	Other (Specify)

	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient :	3□ DOA Other:	4 Nursing Home	5 ☐ Residence 6 ☐ Other (Spec
7	7. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d	Describe how injury occurred

29b. Signature and title of certifier

D63439

29d. Date signed (Month, Day, Year) 06

30. Name and address of person who completed cause ol death (Item 23a) (Type, Print) NANDURI KUSUMA

7600 Cario Mavenue,

State Registrar

31. Date liled (Month, Day, Year) MAR 2 4 2006



3

			For State Registrar	State	of Marylar			t of He		nd M	lental Hyg	giene	Uö	3	58
14.	. 9.		Decedent's Name (First, Middle,	Last)							2. Date of Dea	ıth		3. Time of	Death
	Physicia		 William A	lexander	На	rper					Month March	16.	Year 2006	10:50	a^{M}
	/Medic Examin		4a. Facility Name (If not institution,			200	4b. City,	Town, or L	ocation of	f Death		7	ty of Death		
	LAGIIIII	ici	Bethesda Health	& Rehab	Center		Bet	hesda	1			Mor	tgome	ry	
y S	Funeral			S. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2		8. Date of Birth	h Vaar)	9. Birthp	lece (State or	Foreign
	Director		564-16-7272	1 ⊠ M 2□ F		90 Yrs.	Months	Days	Hours	Min.	09/03/1	1915	New	York	
**	D		Usual Residence of Decedent												
	ylan how		10a, State 10b. County		10c. Ci	ty, Town or Lo	cation						1	0d. Inside Cit	
	a-f a	cto	Maryland Montgo	mery	Bet	hesda								1 🔯 Yes	2 NO
	th th	lre.	10e. Street and Number				10f. Zip	Code				10g. Citizen d	f What Cour	try?	
	death with the Maryland ms 23s or 28s-f show	Funeral Directo	5721 Grosvenor	Lane			20)814				Unite	d Sta	tes	
	ems ems	ner	11. Marital Status	12. Was Dec Armed F	edent Ever in U	J.S. 13.1	Was Dece	dent of Hisporty Cuban,	panic Orig	in? (Spi Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White,		
0	or It		1 Never Married 2 Marrie	If Yes, G	2 🗌 No ive		1 🗆 Yes	2 🔯 No	Specify:			Spec	ify:		
0 0 0 0	irel',	d by	3 ☐ Widowed 4 ☑ Divorced	Year or I	Dates: WW I	I							Cauc		
ה ה	72 t	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	kind of wo	al Occupati ork done du se retired)	ion ring most	of work	ing	16b. Kind of	Business/Inc	dustry	
7	within ne.	m	Elementary/Secondary (0-12)		(1-4or 5+)							Motion	Dict	ura	
7	iled v tygie her t		17. Father's Name (First, Middle, L.	4		FIII	Proc		8 Mother	r's Name	e (First, Middle,			ure	
yıarıd	be find half he do ot	Be									lexande:				
چ	d Mer d Mer nark	은	Sidney S. Harpe			10h Mailie	ag Addross	(Street an			al Route Numbe		m State Zin	Codel	
<u>8</u>	12 st h and 7 is n traun		19a. Informant's Name/Relationshi		. +		•				ac, Mary			0000)	
, L	1 and 1 ealt 1 m 2 ther		Lizette Chanock	c / Daugi		Place of Dispo			1, 10		Date	20c. Locatio		wn. State	
5	Ser it of		1 Burial 2 Cremation		State	cemetery, crei	natory or o	other place)							nd
	t. Pa rtmen rtant:		' 4 □Donation 5 □Other (Spe		Ft.	Linco						Brenty			
Dailmore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: If item 27 is marked other than "naturel, or liems 23s or 28s-1 show any injury or other traumatic event, the Madical Examiner must be notified all once.		21. Signature of Funeral ServicesLi	es-h-	ady_	10	Sir 40 Ro	nple ockvi	ľríbů lle P	ite :	Funeral ; Rockvi	and Ci ille, N	remati Maryla	on Cen nd 208	ter 52
			23a. Part1. Enter the disease, or of shock, or heart failure. List o	omplications that	caused the dea	th. Do not ent	er the mod	de of dying,	such as	cardiac (or respiratory ar	rest,		Approximate Interval Bety	veen
	Physician		Immediate Cause (Final disease or condition	,		NEU	140	NIL	4					Onset and D	eath
	/Medical		resulting in death)	Due to	(or as a consec										
	Examiner		Sequentially list conditions	b											
de %	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):									
	be executed ician and burial-transit	Examiner	that initiated events	c											
Š	e exe ian a urial-		resulting in death) Last	Due to	(or as a consec	quence of):									
2/00	ate by he	Ilcal	1/1	d											
õ	nt the death certificate by the attending phys tached for use as the	Med	IF FEMALE:										f		
X O D	ath ce tlendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregn birth 2 ☐ Feta	aldeath 3	Ectopic p						Date of delive Month	*	'ear
	e death the atten	SICI	1 Yes 2 No	4☐Preg 9☐Unk	nant at time of a	death 5	Other (s)	oecify)							
<u>.</u>	at th	Phy			death but out so	nulting in the u	and and single of		in Dart I		23a Did to	bacco use co	otribute to t	ne cause of d	eath?
ń	law requires that the as been signed by th 2 should be detache	by	Part II. Other significent condition		Acres							/es 2 □ No			Inknown
cords	w require been sig should b	Completed	- N	Merch	ic -		-							-	
ပ	law las b	nple		pro	uc -	ren	al	en	suf	fer	24a. Was autop	an 24	prior to co	psy findings a npletion of ca	available ause of
<u> </u>	The laste has page	Sol							. ,		1 Ves	2 No	death?	2 🗆 No	
Vitai	or Attending Physician: The law ther deam. Director: After this certificate has b in by the funeral director, page 2 s	Be	25. Was case referred to medical examiner?							of Deat	h (Check only o	ne)			
5	hysion his co	2	1 ☐ Yes 2 ☑ No			ER/Outpatier			AP INUI		me 5 Resid			v)	
	ittending Physideath.	on:	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o Injury		28c. Injury a Work?			28d. Describe h	ow injury occ	urred		
VISION	endi eath. or: A	catl	2 ☐ Accident investiga	ation			М	1 🗆 Ye	es 2 🗆 h	VO.					
Ë	ter de iract	ertification:	3 Suicide 6 Could no 4 Homicide determin	10d 289. Plac	e of Injury · At h ding, etc. (Speci		reet, factor	y, office			28f. Location (S City or Tox	Street and Nu. vn. State)	mber or Rura	l Route Num	ber,
2	ital c irs af ral D	O													
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 4 Certifying (Check only 2 Medical E	Physician: To the xaminer: On the and ma	e best of my kn basis of examin nner stated.	owledge, deat ation and/or in	h occurred vestigation	at the time n, in my opi	e, date and nion, deat	d place, th occur	and due to the or red at the time, or	cause(s) and date and plac	manner as s e, and due to	tated. the cause(s)
	othi omple	Me	29b. Signature and title of certifier					c. License				29d. Date sig			
			•	In.	Bu	, mi	2	D 00	57	12	-4	31	1710	6	
	3		30. Name and address of person w	the completed car	· ·						•				
			Truong Bao, M					ive P	ark 7	[err	ace; Ge	rmanto	wn. Ma	ryland	l
	Sta	ato	31. Date filed (Month, Day, Year)		Registrar's Sign								. ,		
Ż	Registr		MAR 24	2005	ance 1	J. AND	ande								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** Mary Virginia Harris FEBRUARY 5 2006 10:30 PM /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CECIL VA MARYLAND HEALTH CARE SYSTEM PERRY POINT 8. Date of Birth (Month, Day, Year)
Oct. 22, 1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months Days Hours Min 83 Yrs. Director 577-20-5074 unknown Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1728 Biggs Highway 21911 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1945 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 (XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown Telephone Operator unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aimee Saylor, Decedent Affairs Bldg. 361, Room GAll6A, VAMC, Perry Point, Maryland 21902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of the Important: if Ite any injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cemetery 03/29/06 Owings Mills, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Qr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) PNEUMONIA UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? γ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Linknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2**X** No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Dther: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be determined 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 D42800 FEBRUARY 6, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS BIONDO, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902 32. Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

PHYSICIAN:

2

NAME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Shirley Jean Hayward /Medical March 29. 2006 6:40 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cumberland

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, July 28) Memorial Hospital Allegany **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 214-34-2187 1 ☐ M 2 📉 🗶 70 Director 1935 West Virginia Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at WV. Mineral Director Piedmont XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ¥ith ö Ashfield St. 83 or items 23a 26750 United States Completed by Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 22 No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes > No Specify: 3 ☐ Widowed 4 ☐ Divorced natural 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housework 12 Homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Howard Grant Edith Jose ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Vicki Alexander/ daughter 305 Likens St., Westernport, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot ance. 1 ☐ Burial 🌣 🗖 Cremation 3 ☐ Removal from State 03/30/ Cumberland Crematory Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Boal Funeral Home ple 111 Church St., WEsternport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit Exami Due to (or as a consequence of): Box 68760, Physician/Medicai 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetel death 3 Ectopic pregnancy 4☐Pregnant at time of death Month Year Day P.0. been signed by the should be detached 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2√√ No page 2 s 24a. Was an autopsy 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient this 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 SNatural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide ŏ tale Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year) March 30 2006 D60478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Afaq Ahmad 625 Kent 31. Date filed (Month, Day, Year) Cumberland, MD 21502 Ave 32. Registrar's Signature State

Registrar

MAR 3 1

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2006 12:31p^M William Thomas Hammer March 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Center for Hospice Care Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 228-12-1518 83 June 18, 1922 Bluemont, VA Usuat Residence of Decedent 10a. State 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2X No Freeland MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21053 1949 Freeland Road 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry $\overset{\text{Etementary/Secondary } (0\cdot12)}{12}$ College (1-4or 5+) Intelligence Officer Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Wilma Simpson Robert S. Hammer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1949 Freeland Road Freeland, MD 21053 Sandra R. Bryan/Daughter 20b. Place of Disposition (Name of cemetary, crematory or other place)
Yorktowne
Cremation Service 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State April 4 ☐ Donation 5 ☐ Other (Specify) York, PA 17404 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St. New Freedom, PA 17349 23a. Parl. Ent of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or finant failure. List only one cause on each line. Onset and Death tmm liate Colse (Final Congestive day disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pag I.

Physician /Medical Examiner

The law requires that the death certificate be executed

certificate:

within 24 hours a To the Funeral C completely filled o the Hospital

Box 68760,

P.O.

Records,

of Vital

Division

or Attanding Physician:

Physician

/Medical

Examiner

Funeral

Director

ahow

rthan "natural", or Itama 23a or 28a-1 aho The Medical Examiner must be notified at

Pages 1 end 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic avant, Iha M

permit. Pages 1 Depertment of H Important: If Ite any Injury or ot once.

Baltimore, Maryland 21215-0036

Directo

Completed

Be

IF FEMALE: 25. Was case referred to medical

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

attending physicien and for use as the burial-transit Physician/Medical ed by the a δ Completed Be After thi Medical Certification; the filled in by

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performe 1 ☐ Yes 2 ØNo 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ➤ No 2 X No

1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 2 Accident 5 Pending

28a. Date of tnjury (Month, Day Year) investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tille of iffier

29c. License number 25 205 March 31, 2006

person who completed cause of death (ttem 23a) (Type, Print) M. Charles St. Bolto. Md 21208

7 2006

6701 6 Bmc

31. Date filed (Month, Day, Year) APR 9 7 State Registrar

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene (1.1)

10962

		State of Maryland /	Certificate of Death	Reg. No.	0 10300
		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
	Physician	Grace M. Hammond		March 26, 2	006 11:25AM
	/Medical Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	ocation of Death 4c. County	of Death
3		Harborside Healthcare-Larkin	n Chase Bowie	Prin	ce Georges
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director	578-56-8414 1□M 2\F		Dec.9,1940	Wash.,dC
	2	Usuel Residence of Decedent			
	tryler thow	10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits 1☑ Yes 2□ No
	a Ma	Md. PG Gle	endale		
	or 2	10e. Street and Number	10f. Zip Code	10g. Citizen of V	Vhat Country?
	72 hours after deeth with tha Marylend "natural", or items 23s or 28s-f show idical Examiner must be notified at efect by Funeral Director	10017 Dubarry Street	20769	United	d States
	dee man	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- 14. Race Rican, etc.) Blace	e - American Indian, k, White, etc.
0	afte of it	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	1 ☐ Yes 2 ② No Specify:	Specify	
8	"natural", o	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Black
5	ed within 72 ho ygiene. her than "naturi it, tre Medical Completed	15. Decedent's Education (Specify only highest grade completed)	e. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. Kind of Bu	usiness/Industry
2		' Elementary/Secondary (0-12) College (1-4or 5+)			1 0 1
2	filed with Hygiene. other than ent, ir a	12	Teacher's Aide		ol System
Ē	d out	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surnam	(0)
\Z	Me Signal	George C. Jackson		Dent	
lar	and and is me	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rur	al Route Number, City or Town,	State, Zip Code)
-	C = N -	Charles Hammond/husband	10017 Dubarry Stre Gleudale, Maryland of Disposition (Name of	20769	O: - O: 1
Baltimore, Maryland 21215-0020	t to to to	20a. Method of Disposition 20b. Place cemel 1 □ Seurial 2 □ Cremation 3 □ Removal from State	ery, crematory or other place)		City or Town, State
E	Pe man man man man man man man man man man	4 □ Donation 5 □ Other (Specify) Ceda:	r Hill Cemetery 3	/31/06 Suit	land, Md.
a	permit. Depertrimports Imports any Inji	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	lodges & Edwa	rds F.H.
8	89 = 89	Marines Zelumines	3910 Silver Hill	Rd Suitla	nd Md 20746
		23a. Part1. Enter the disease, or complications that ceused the death. Do shock, or heart failure. List only one ceuse on each line.	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
1	Physician	shock, or heart failure. List only one ceuse on each line.	1		Onset and Death
أيسي المسترا	/Medical	Immediate Cause (Final disease or condition	Angltoma		· ·
	Examiner	resulting in death)	a consequence of):		
	<u> </u>		2 00/100400/100 0//. 1		
/	requires that the death certificate be executed seen signed by the ettending physician end hould be detached for use as the buriel-transit etect by Physician/Medical Examiner	Sequentially list conditions b.	s consequence off.		
ó	Pe die M	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			İ
68760,	rtificate be ng physicle s es the bu	that initiated events Due to for as a	a consequence of):		
89	ntificate ng physi	resulting in death) Last	, ,		
Вох	aath car ettendin for use clan/N	d			
	at tha daath ca d by the ettendi letached for use Physician/	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobacco use cor	ntribute to the cause of death?
P.0	that tha de ed by the detached	To Shire 100000		1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
	ras that signed I be det	Iselnic acces			
Division of Vital Records,	tuira: n sig uld b	Old Cerebrovaxula	o Accordant	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to
ပ္ပ	w require been si should	an well willed	r reciced	penomed	completion of cause of deeth?
æ	The lew requir sate has been s paga 2 should			1 □ Yes 2 ဩ No	1 □ Yes 25kNo
ल	certificate rector, pag	25. Was case referred to medical	26 Place of Deat	th (Check only one)	12.00 24.00
=	Physician: this certific iral director,	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	Othor	ome 5 ☐ Residence 6 ☐ Othe	er (Specify)
o	Physic rthis course direction T. To		Time of linjury at Work?	28d. Describe how injury occurr	
9	Attending I ir death. ector: After by tha funa Ification	1 ☑Naturel 5 ☐ Pending (Month, Dey Year) 2 ☐ Accident investigation	Injury Work? M 1 ☐ Yes 2 ☐ No		
S	death. ctor: A y tha fu	3 Suicide 6 Could not be 28e. Place of Injury - At home.	farm, street, factory, office	28f. Location (Street and Numb	er or Rural Route Number,
$\frac{5}{2}$	tal or Attending P is aftar death. al Director: After ti ad in by tha funara Certification;	4 Homicide determined building, etc. (Specify)		City or Town, State)	
	Hospital 24 hours Funeral etely filled	29a. Certifier 1 Certifying Physicien: To the best of my knowledge	pe, death occurred at the time, date and place.	and due to the cause(s) end ma	inner as stated.
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funal Medical Certification	(Check only one) 2 Medical Examiner: On the basis of exemination a and manner steted.			
	To the Ho within 24 I To the Fu completel	29b. Signature and title of certifier	29c. License number	29d. Date signer	d (Month, Day, Year)
	- S - O	I MD	DKINZX	4-20	70
	0	30 Name and addition of passes who and all the same of death (in a con-	(Type Print)	(70	4
	3	30. Neme and widdless of person who completed cause of death (Item 23e ADITYA CHIPPA MD 600	Distant Allo Suite	231 Annapolis	MD 2140/
	C	31. Date filed (Month, Day, Year) 32. Degistrar's Signature	Diagony /Ive suite	201 Illiaport	1000
	State Registrar	APR 0 7 2006	boat 1		
		THE PERSON AND TO	The state of the s		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day March 22, Louis Madison Knight 2006 6:22am^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 215-26-1914 92 May 29, 1913 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2X No Maryland Montgomery Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 13120 Cool Brook Lane 20871 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Millworker Carpentry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emmett Lewis Knight Winnie Gaynelle Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Enkiri (Dau hter) 4616 Olympia Avenue, Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/22/06 Alexandria, Virginia 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Devol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 231 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Seps15 days /Medical Due to (or as a consequence of): Examiner tract infection urinary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the deeth certificate be executed anding physicien and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ◯ No 24a. Was an autopsy performed? Yes 26 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury f Director: A d in by the ft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined within 24 hours after dea To the Funeral Director completely filled in by th 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Flicia J. Mistry D59738 March 22, 2006 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Drive Rockville, MD 20850 Alica T. Mistry 9901

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 24

2006

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 20, Jeanette Kitwell March 2006 9:15 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08/29/1914 Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔯 F Director 216-46-3723 91 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ehow other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 201 Russell Ave. 20877 or Iteme 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 Widowed 4 Divorced White "natural", 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Food and Drug College (1-4or 5+) the C Elementary/Secondary (0-12) Federal Worker Administration marked other permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: if I lem 27 is marked oth eny Injury or other treumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank D. Kitwell Eleanor Henneberger ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert McCarthy Esq./ Guardian 4405 East West Highway; Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 3/28/2006 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 21. Signature of Furieral Service Licenses 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center Pintym 1040 Rockville Pike; Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 days Physician /Medical Due to (or as a consequence of) Examiner S_quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed as the burial-transit Exami that initiated events resulting in death) Last the attending physicien and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decadent pregnant in the past 2 months?
1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy ō Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 🗌 Yes 2 No 3 Probably 4 Unknown peed 24a. Was an autobsy perionn 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate 1 Yes To the Hospital or Attending Physicien: 25. Was cas eferred to medical examiner? Be 26. Place of Death Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA this Director: After the Vanner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours are: To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hakim Morsul 9901 Medical Center Drive Rockville MD 20850 Registrar's Signature State Registrar

	•		1 - State Registrar	State of		d / Depa	artment of rtificate o	Health a		ntal Hygi	-) ₅	10965
			Decedent's Name (First, Middle,	Last)					- 2	2. Date of Death	1		3. Time of Death
	Physici		EDNA		KING				,	Month IARCH	Day	Year	0 007 M
	/Medic Examir		4a. Facility Name (If not institution,	give street and nur			4b. City, Town	or Location of		MARCH	19,2 4c. County		9:29A "
	LXamii	ICI	Southern Mary			1		nton			Danin	~ ~ ~	eorge
	Funeral				7. Age (In yrs.		If Under 1 Yea	r If Under 2		B. Date of Birth		9. Birth	place (State or Foreign intry)
	Director		216-16-0263	1 ☐ M 2 🛣 F	84	Yrs.	Months Day	s Hours	Min.	(Month, Day,			ryland
	P .		Usual Residence of Decedent							MIY Z	77126		
	arylar show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	88a-f	Director	MD Montgo	omery	G	erman						1	1 Xes 2 No
	with th	D	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cou	intry?
	s 23	Funeral		Les Roos				374	. 0.10	, , , , , , , , , , , , , , , , , , ,	U.S.		
	ltam Itam	nu	11. Marital Status	Armed Fo		.5. 13.	Was Decedent of If Yes, specify Co	r Hispanic Orig iban, Mexican,	in? (Spec , Puerto Ri	ity Yes of No- ican, etc.)		ck, White	ican Indian, , etc.
36	Ir, or	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Vivorced	If Yes, Giv	10		1□Yes 2⊠N	o Specify:			Specif	v: B1	ack
21215-0036	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show alfall Exa illustr, ust be ruillised at	ted	15. Decedent's	Education		16a, Dece	dent's Usual Occ	upation		1	6b. Kind of B		
212	c *_ 3	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1	-40r 5+)	(Give	kind of work dor DO NOT use reti	ne during most red)	of working	7			•
21	M Sept 4	NO.	6th	Conogo (1		Dome	estic				Priv	zate	
p	be filed vital Hygie	Be (17. Father's Name (First, Middle, L.	ast)				18. Mother	r's Nam <i>e (</i>	First, Middle, M			
la		70	Clarke A. I	orsey				Ma	mmie	м. та	aylor		
Maryland	and and sum		19a. Informant's Name/Relationshi				ng Address (Stre				•		
	1 and 2 Health tem 27 i		Keith Jackson	ı- Great	. Nephe	w 18	542 Eag	gles R					
Baltimore,			20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation	B □Removal from S		lace of Dispo emetery, crea	sition (Name of natory or other p	lace)	Dat	te 2	0c. Location	City or T	own, State
E	permit. Pages Department of Introduced Important: If ite		*4 ☐ Donation 5 ☐ Other (Spe	ecity)	Emo	ory G	cove Ce	em 3	/27/	06	aithe	rsb	urg, MD
Sall	permit Departr Importa any inji		21. Stanature of Funeral Service Li	cens	1	. 1 22	. Name and Add	ress of Facility	Sno	wden E	unera	al H	ome, PA
_	90 E 8 3F		Care 1	Ane	all	/ 24	46 N. V	Vashin	gton	St Ro	ckvil	le,	MD20850
П.			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that can't one cause on e	aused the death ach line.	n. Do not ent	er the mode of d	ying, such as c	cardiac or i	respiratory arre	st,		Approximate Interval Between Onset and Death
	Prysician	6 11	Immediate Cause (Final disease or condition resulting in death)	a Acu	te Myc	card:	lal Inf	arcti	on				Onsot and Death
	/Medical Examiner		rodaling in doubly		or as a consequ								
		-	Sequentially list conditions,	U.	.al Fai orasa consequ								10 Years
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				ry Dise	2250				10.	10 Years
Ć	be executed ician and burial-transit	Exa	resulting in death) Last	U	or as a consequ		1 2200	- ubc					IO TEALS
760,	te be ysicia te bur	cai		d					·				
9	ntifical ng phy as th	Jed	IF FEMALE:	F-52			_						
Вох	death certifica e attending ph od for use as th	an/h	23b. Was decedent pregnant	23c. If yes, outo	come of pregna		lEctopic pregnar	icv				te of deliv	•
	e dea the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregn: 9□Unkno	ant at time of de		Other (specify)				Mic	nth	Day Year
P.0	that the de led by the a detached f	Physician/M	9 Unknown			let - t - e				00. 8:4			
ŝ	es be	þ	Part II. Other significant condition	s contributing to de	ath but not rest	uiting in the ui	nderrying cause (given in Paπ I.					the cause of death? bably 4 □Unknown
O.C.	w requir been s	etec								10.10	212010	0	
Record	2 55 29	ompieted								24a. Was an autopsy perform		Were auto prior to co death?	opsy findings available empletion of cause of
-	ilcian: The I certificate ha rector, page	O								1 Yes 2		1 Yes	X No
Vital		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:						Check only one	<u> </u>		
of	Physical di	. To	27. Manner of Death		npatient 2 🔀 of Injury h, Day Year)	28b. Time of	t 3□ DOA 28c. Inj			5 ☐ Resider			<i>(y)</i>
on	Attanding Phy r death. actor: After thi by the funeral o	tion	1 ZNatural 5 ☐ Pending 2 ☐ Accident investiga		h, Day Year)	Injury	W	ork? ⊒Yes 2.⊟N			, , ,		
Division	or Attan after deat Diractor: in by the	ertification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place	of Injury - At ho	me, farm, str	eet, factory, offic	9	28	f. Location (Stre	eet and Numb	er or Run	al Route Number,
Ö	s afte	Cert	4 Hornicide	bullair	ng, etc. (Specify	"				City or Town,	State)		
	hour hour unar	edical (29a. Certifier 1 Certifying	Physician: To the caminer: On the ba	best of my know	wledge, death	occurred at the	time, date and	place, an	d due to the car	use(s) and ma	inner as s	stated.
	To the Hospital or Attanwithin 24 hours after deatl To the Funaral Diractor: completely filled in by the	ledi	urie)	and mann	er stated.	tion and/or in			n occurred				
		Σ	29b. Signature and title of certifier	\mathcal{A}	100-	Alli		nse number	•		d. Date signe		
,	5		1 I Tal	cde	rer	1,0	D0	036538	8		March	24,	, 2006
			30. Name and address of person w										
	Sta		Marc Leffer, 31. Date filed (Month, Day, Year)	/503 St	a mintende Ciamas	Acces 100	A .	on, Ma	aryla	and 20	7.35		
	Registr	_	MAR 24	2006	was to	ture							

			For State Registrar	State of Ma	arylan	-		nt of Hea te of De		Mental Hy	/giene	105	10966	
	Physicia	an	Decedent's Name (First, Middle, Last) Marlene Diane LEVIN								eath Day			
,	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of E						ration of Dea	March 21, 2006 11:30 PM				
	Examin	er	Shady Grove Adventist Hospital				Rockville			uı	Montgomery			
Ŧ	Funeral		5. Social Security Number 6. Sex	7. Age		ast birthday)		r 1 Year If			irth	9. Birth	pplace (State or Foreign untry)	
	Director		219-60-1448	M 2□F X	54	Yrs.	WOTHING	54,5			8, 195		ginia	
	death with the Maryland sms 23a or 28a-f show		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. In side City Limits	
:		tor	Maryland Montgomery Potomac										1 ☐ Yes 2 No	
	or 28	Directo	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	untry?	
	8 238		10609 Farmbrooke Lane 11 Marital Status 12. Was Decedent Ever in U			20854				O		d Stat		
200	should be filed within 72 hours after death with the Marylan and Mental Hygiene. Marked other then "natural", or leans 23a or 28a-f show marked other then "natural", or leans 23a or 28a-f show marke cevent, the Medical Examinar must be rediffed at	by Funeral	11. Marital Status 1						spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) Specify:			14. Race - American Indian, Black, White, etc. Specify: white		
5	z nou satura ical E		15. Decedent's Education (Specificantly highest and a completed)			16a. Deced	lent's Ust	al Occupation	n na most of w	net in a	16b. Kind of Business/Industry			
and 21215	in 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give kind of work done during most of work life. DO NOT use retired) Teacher/LPN				rking	Education/Medical			
	tygien her th	Co	17. Father's Name (First, Middle, Last)				-							
	d be t	o Be	2017-11-2000-1					18. Mother's Name (First, Middle, Main Elizabeth Powel						
	nd Men marke	7	Hyman Walman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing				g Addres	s (Street and		Pural Route Num		wn, State, Z	ip Code)	
≥ ນົ	and 2 salth a n 27 is		Sandra Marantz, Si	ster					Lane	, Potoma	c, MD	20854		
	permit. Pages 1 and 2 should b Depertment of Health and Ments important: if item 27 is marked eny injury or other traumatic s once.		20a. Method of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Re	moval from State	20b. P	lace of Dispo emetery, cren	sition (Na natory or	me of other place)	1	Date	20c. Locati	ion - City or 1	Town, State	
			4 □Donation 5 □ Other (Specify)		Met					3/24/06	Alex	andria	ı, VA	
ם מ			21. Signature of Huneral Service License			T/	archi	nd Address of Insky F	Phreu	Funeral	Home			
	Physician /Medical Examiner		23a. Para Ester the disease, or complic	ations that caused	the death	n. Do not ent	54 Ca er the mo	irroll de of dying, si	St.	Wash	ington arrest,	, DC	20012 Approximate Interval Between	
F			tmmediate Cause (Finat Onset and Death											
ı		16	resulting in death) a. \[\frac{1465}{2} \cdot \cdot \frac{1}{2}											
			Sequentially list conditions, b.	Due to (or as		uence of):	NIC							
	ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					respiratory fai				\ 70		
ב כ	en endrial-tra	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):				,					•		
00/0	Ine law requires that the death certificate be executed ate has been signed by the ettending physicien end page 2 should be detached for use es the burial-transit	dicai	d.	142	10 6	766	103	1 och						
YO :	ding p		IF FEMALE: 23	Sc. If yes, outcome	of pregna	ncv					224	Date of deli	uon/	
	s etten d for u	iclan/Me	in the past 12 months?				□Ectopic pregnancy □ Other (specify)				23d. Date of delivery Month Day Year			
)	by the	Physi	1 □ Yes 2 No 9 □ Unknown	9□ Unknown										
cords, r	igned be de	ğ	Part It, Other significant conditions cont	ributing to death be	ut not resu	ulting in the ur	nderlying	cause given in		d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown				
	requi	Completed	(1) peria											
֝֞֝֟֝֓֞֝֟֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֡֓֓֡֓֡֓֓֓֡֓֡֓֡֓֡	scentificete has b lirector, page 2 sl	dmo	HIbefension							aut	Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?			
NICAL	an: I tificeto tor, pa	Φ.	25. Was case referred to medicat					1 ☐ Yes 2 ☐ 26. Place of Death (Check only one)			2 No	Yes 2 Ne		
	to the prospital or Atlanding Prystician: the within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	To B	examiner? 1 □ Yes 2 No	spitat:	Other					Home 5 ☐ Residence 6 ☐ Other (Specify)				
5 6			27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)			28b. Time of lnjury at Work?			28d. Describe how injury occurred					
INISION		cat	2 Accident investigation 3 Suicide 6 Could not be					M 1 Yes 2 No			(Street and N	et and Number or Rural Route Number,		
<u> </u>	after after Direction	Certification;	286. Place of trijury - At home, farm, street, factory, office building, etc. (Specify)									iar riodio riombor,		
:	e Hoepit 24 hours Funera letely fille	Medical C										stated. to the cause(s)		
:	withir To th comp	Me	29b. Signature and title of certifier				29c. License number				29d. Date signed (Month, Day, Year)			
	2		Vina Gand				Daller				Wdich 55 500R			
	-		30. Name and address of person who con	mpleted cause of d	eath (Item	23a) (Type,	Print)	9111	G	erma	ntry	y mi	758056	
	Sta	te	31. Date filed (Month, Day, Year) MAR 2 4 200	32 Registra	ar's Signa	ture	1							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** March 22, 2006 7:45 Lanen /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hillhaven Nursing Center, Inc. Adelphi If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑** M 2□ F 4, Massachusetts 1922 83 Director 013-16-3319 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28a-1 show any injury or other traumatic event, the Medical Evanting or unal be tradified at once. 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 USA 13 Memory Court Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ WWII 3 Noticed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Colfege (1-4or 5+) Utilities Commissioner State Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edward J. Lannon Florence Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Sellner/Daughter 13 Memory Court, Silver Spring, MD 20904 20b. Pface of Disposition (Name of 20c. Location - City or Town, State March 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2006 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, T Acko MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** 25 Years Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of) Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ned by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 HUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) Hospital: 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident Diractor: 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital or # within 24 hours after within 24 hours a To the Funeral L t 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32 Registrar's Signature

Charles M. Benner, M.D.

31. Date filed (Month, Day, Year) MAR 2 4

D31563

10801 Lockwood Drive, #205, Silver Spring, MD 20901

March 23, 2006

DHMH 17 Rev 1/2001

Registrar

		1 - For State Registrar	State of Maryl	and / Depa <i>Cel</i>	artme rtifica	nt of He <i>te of D</i>	alth and eath	Mental Hy	/giene	U5	19969
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Loraine B. McGee						2. Date of D Month March	Day 21,2006	Year	3. Time of Death 5:50pm M
Examin		4a. Facility Name (If not institution, give s Suburban Hospita	.1		Bet	hesda	ocation of Dea		4c. County Mont		
Funeral Director		5. Social Security Number 578-34-3270 Usual Residence of Decedent	7. Age (In)	vrs. last birthday) Yrs.	If Und Months		If Under 24 Hr Hours Mir	Month, D	irth <i>ay, Year)</i> 20 , 1915	Col	place (State or Foreign intry) Wa
ne Maryland 8a-f ehow	Director	10a. State 10b. County MD Montgome		City, Town or Lo	a						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the		10e. Street and Number				ip Code			10g. Citizen of N		•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at one.	by Funeral	7205 Marbury Rd 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 □Yes 2 X No If Yes, Give		Was Dec f Yes, sp		panic Origin? (Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)			ican Indian, , etc.
d within 72 hours af giene. or then "natural", or the Medical Exemi	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: cation completed) College (1-4or 5+)	(Give	kind of w	ual Occupati ork done dur use retired)	on ring most of we	orking	16b. Kind of Br		ndustry
Hygier Ther th		17. Father's Name (First, Middle, Last)	4	Homen	naker		9 Mothodo No	ma (First Middle	Own		
hould be file A Mental Hy narked oth	To Be	Howard Baker					Madge M	lerrill			
id 2 sh Ith and 27 ie m trsum	- 1	19a. Informant's Name/Relationship (Type Robert M. McGee/							oer, City or Town, vy Chase		
ages 1 ar ant of Heal ht: if item y or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	b. Place of Dispo cemetery, crer ational	sition (Na natory or	ame of other place)		Date 23-06	20c. Location -	City or T	own, State
permit. Pages Department of Important: if it eny injury or o		21. Signature of Funeral Service License		22	Name a José	and Address eph Gav	of Facility Wler's	Sons, IN			
cate be physicie the bur	dicai Examiner	23a. Part1. Enter the disease, or comply shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, resulting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Arrhythmi Due to (or as a con Myocardia Due to (or as a con Due to (or as a con	a sequence of): 1 Infaro sequence of).			such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
the death certing the attending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 ☐ Yes 2 ② No 9 ☐ Unknown	3c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3]Ectopic] Other (s	oregnancy specify)				te of deliv	ery Day Year
w requires that the de been signed by the should be detached	Š	Part II. Other significant conditions con Advanced Dementia		resulting in the u	nderlying	cause given	in Part I.		tobacco use cont Yes 2 ☐ No	ribute to	the cause of death?
sicien: The law re certificete has ber irector, page 2 sho	Completed							24a. Was auto perf 1 Yes	ormed? (Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 No
ysicien: is certific director,	Be	25. Was case referred to medical examiner?	ospital:	Effento				ath (Check only			
	tion: To	1 Yes 2 No	28a. Date of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury		28c. Injury a Work?	4 □ Nursing t s 2 □ No		idence 6 Oth		fy)
To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	at home, farm, streecify)				28f. Location City or To	(Street and Numb own, State)	er or Rui	al Route Number,
in 24 hour in 24 hour he Funera pletely fills	Medicai (one)	ician: To the best of my ler: On the basis of exam and manner stated.	knowledge, death nination and/or inv	estigatio	at the time, n, in my opin	date and place ion, death occ	e; and due to the urred at the time	cauce(e) and ma , date and place,	and due	taled to the cause(s)
To to To to com	Σ	29b. Signature and title of certifier		00.15		D547			29d. Date signed March 2		
		30. Name and a cress of person who could bartan W. Leonard 31. Date filed (Month. Day, Year)		Old Geor	geto		, Bethe	sda,MD	E20-F1-10-51110-5-		1177
Stat Registra		31. Date filed (Month, Day, Year) MAR 2 4 20	306	15 14	and i	B					

		•	For State Registrar	State of M	arylan	•	artmen					giene Reg. No.	005	0970
15	1/1 5/3		Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath		3. Time of Death
	Physici /Medic	al	Revekka 4a. Facility Name (If not institution,	Maslova			4h City	Town or	Location of		Month March	21 4c.		12:30 P M
	Examin	er	10250 Westlake					thes		or Douter			ontgome	
Variable of the second	Funeral Director				-	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day	h v. Ye <i>ar</i>)		place (State or Foreign intry)
1	-		Usual Residence of Decedent								nagase	7,1	JOJ Kuss	
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits 12□Yes 2□ No
	Ba-1 e	cto	MD Montgor	nery	В	ethesd								
	vith th	Director	10e. Street and Number				10f. Zip		017			-	zen of What Cou	intry?
	s 23e		10250 Westlake	Dr. #915	Ever in II	C 12	Was Door		817	igin? (Spe	ocify Ves or No	U.S	• A • 14. Race - Amer	ican Indian
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then *natural', or items 23e or 28e-f ehow amportant: If item 27 ie marked other then *natural', or items 23e or 28e-f ehow amportant: If item 27 ie marked other then the marked of the mark	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	Armed Forces?			If Yes, spec	72	Specify:		ecify Yes or No- Rican, etc.)		Black, White	, etc.
9	hour tural	edt	15. Decedent's			16a, Dece	dent's Usua	al Occupa	ation			16b. Ki	nd of Business/l	ite ndustry
21215-0036	n na	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)	F./\	(Give	kind of wo DO NOT us	rk done d se retired	during mos 1)	t of worki	ng			,
212	d with giene ir the	E	Elementary/Secondary (0-12)	Cotlege (1-4or	J+)	Econo	mist					Rus	sian Fe	d. Govt.
	al Hygotha	Be C	17. Father's Name (First, Middle, L.	ast)					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	
/lar	uld by Menta vrked	10 1	Joseph Ginsburg						Margo)lya	(unkn	own))	
Maryland	sho and I		19a. Informant's Name/Relationsh					,					r Town, State, Z	ip Code)
≥,	and and m 27		Irina A. Lubens	ky-granddau		_			reen					
ore	of H		20a. Method of Disposition	3 □Removal from State	1 0	Place of Dispo cemetery, crea	matory or o	ne or ther plac			Date		ocation - City or	
Ë	Pag tment tant:		`4 □ Donation 5 □ Other (Sp		Pa	erklawr			1	3-23			kville,	
Baltimore,	permil Depar impor any in		21. Signature of Funeral Service L	Store	ine	us	1091	Rock	kvill	e Pi	ke Rock	vili	neralDi e, MD 2	rection Inc 0850
	Physician /Medical		23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	ary	di	ter the mod	le of dyin	1.	cardiac o		rest,		Approximate Interval Between Onset and Death UCANS
3760,	ate be executed mysician and he burial-transit	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or as c. — Due to (or as d. —										
.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fete	el death 3	⊒Ectopic pa ⊒ Other (sp		,				23d. Date of deli Month	very Day Year
Δ.	8 <u>15</u> 8	by	Part II. Other significant condition	ns contributing to death I	out not res	sulting in the u	inderlying o	ause giv	en in Part I	t.	23e. Did to			the cause of death?
Vital Records,	e law requir has been s je 2 should	Completed				,					24a. Was	osy	prior to d	topsy findings available completion of cause of
= 3		Con									1 ☐ Yes	mjed? 2×No	death? 1 ☐ Yes	2 No
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or		n (Check only o			
of	ing Phys	ion: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury	28b. Time of Injury		28c. Injur Wor	y at		me 5 Resident		6 Other (Specify occurred)	afy)
Division	or Atten ifter deal Director: in by the	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 390 Place of to	ijury - At h tc. <i>(Specii</i>	ome, farm, st fy)			103 2	-	28f. Location (3 City or Tox			ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai C	29a. Certifier 1 Certifying (Check only 2 Medical E	g Physician: To the best Examiner: On the basis of and manner s	of examina	owledge, deat ation and/or in	th occurred nvestigation	at the tir n, in my o	me, date ar pinion, dea	nd place, ath occuri	and due to the red at the time,	cause(s)) and manner as d place, and due	stated. to the cause(s)
	To the To the compl	Me	29b. Signature and title of certifier	Town bor 4	lan.	my	29	c. Licens	e number	6		29d. Da	te signed (Monti	n, Day, Year)
	3		30 Name and address of person of	who completed cause of	deal (Iter	m 23a) (Type	Print)	D. Ke	G-	100	Rooky	110	mD.	, 2006 1085]
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 3	32 Regist	rar's Sign	ature	Sold Sold Sold Sold Sold Sold Sold Sold	1/10	, _ /	100)	NUCN VI	110	1111/ 0	

WILLER,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** p^{M} Sheila M. McCarty March 24 2006 4:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 □ **3 F** Yrs 19 579-34-3663 78 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 St. Luke Circle 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 25 No Specify: White ģ 3 ☐ Widowed 4 No Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Teresa Wright Ralph L. McCabe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David McCabe/brother 1806 Bennedict Road Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Qurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cem 3/28/2006 Westminster, MD 22. Name and Address of Facility Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral al al 23a. Part1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last morne At BSUN Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No

Pnysician /Medical Examiner

Funeral

Director

or 28a-f show

Items 23a

e filed within 72 hours after de la Hygiene.

s 1 and 2 should be filed wi f Health and Mental Hygien item 27 Is markad other th

item 27

Department of H Important: If ite

injury

any it

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

traumatic event, the Medical Examiner must be notified at

The law requires that the death certificate be executed physician and s the burial-transit attending p the s certificate has b lirector, page 2 s 0 this

of Vital To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Division in by the 7

27. Manner of Death Certification:

5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 🗌 Suicide 4 Homicide 29a. Certifier

29b. Signature and title of certifier

Aberearly Brown

28a. Date of Injury (Month, Day Year) Płace of Injury - At home, farm, street, factory, office building, etc. (Specify)

nanner stated

uscheusly

28b. Time of

12 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examiner

28c. Injury at Work? 28d. Describe how injury occurred 1 Tyes 2 🗌 No

with occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

100 2 here theme Suto 201, westmoneer MID

29c. License number n37049 eth (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

March 24th 2006

State Registrar

31. Date filed (Month, Day, Year) MAR 2 7 2006

30. Name and address of person who completed cause

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 22, Day 2006 **Physician** Margaretha Elizabeth Murray 1951 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 😡 F 82 Director Pennsylvania 219-16-6465 June 1, 1923 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
The file T 1 is marked other than "naturel", or Iteme 23e or 28e-f ehow ant: If item 27 is marked other than "naturel", or other traumatic event, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Carroll Westminster 1 ☐ Yes 2 XNo Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21157 USA 515 Hook Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No white Specify P Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Retail Store 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Schlentz Louis Lewert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda A. Simms, daughter 1710 Bachman Valley Dr, Westminster, MD 21157 Important: If iten, eny injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Method of Disposition Entonbment
1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Green Mount Cemetery | 03/28/2006 Baltimore, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a cor Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) 4☐Pregnant at time of death signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 🗆 No 1 Tyes 3 Probably Linknown should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 hes autopsy performed certificate 1 ☐ Yes To the Hospital or Attending Physicien: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only o 27. Manner of Mai Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Inpatient **ER/Outpatient** 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after deat • Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deals occurred at the time, date and class, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fund completely f 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 033561 WS (Item 23a) (Type, Print) Progress way #114 James 31. Date filed (Month, Day, Year) State Registrar

ADH BRIAN JEREMY MILLER 06-2214

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland / D	epartment of F Certificate of			giene 006	10974
П	Physici	an	Decedent's Name (First, Middle, Last)	MILLED			2. Date of Dea Month MARCH	$31^{\text{Day}}, 2006^{\text{Year}}$	3. Time of Death O150 A M
b.	/Medic Examin		BRIAN JEREMY 4a. Facility Name (If not institution, give s	MILLER treet and number)	4b. City, Town, o	r Location of Death		4c. County of Dea	
			9100 TURKEY HILL RO		LAPLATA			CHARLES	
ř	Funeral Director		217-11-3760	7. Age (In yrs. last birth	day) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day JAN . 17	(, Year) 9. Bir (, 1983 MA	thplace (State or Foreign ountry) RYLAND
	iand ow	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	•-f •h	ctor	MARYLAND CHARLE	S POMI	FRET				1 ☐ Yes 2 ☒ No
	n with the	i Dire	10e. Street and Number 8185 LANCELOT WA	Y	10f. Zip Code 206	75	1	U.S.A.	ountry?
96	should be filed within 72 hours after death with the Maryland and Mental Hygiene. The Hygiene 28a or 28e-f ehow marked other then "neturel", or iteme 28a or 28e-f ehow imatic event, the Madical Examiner must be notified at	y Funeral Director	1XXever Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZONo If Yes, Give	13. Was Decedent of H If Yes, specify Cub. 1 ☐ Yes ※☐XNo	dispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Situ	e, etc.
00	2 hours eturel', ical Ex	ted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:	Decedent's Usual Occup	ation	4.5-	16b. Kind of Business	HITE //ndustry
Maryland 21215-0036	I within 7 liene. r then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	Give kind of work done life. DO NOT use retire PUTER SYS			J.B.I. T	ECHNOLOGY
밀	be filed hal Hygic od other event, E	Be	17. Father's Name (First, Middle, Last)				ne (First, Middle, i	Maiden Sumame)	
<u>√</u>	should the market market umatic	ဥ	BRUCE WAYNE MIL 19a. Informant's Name/Relationship (Type		Mailing Address (Street			ETH RIGB	
	s 1 and 2 should f Health and Men flem 27 is marke other traumatic		BRUCE MILLER -		B5 LANCEL				
altimore,	M C		20a. Method of Disposition 1 ☐ Burial ②☐Çremation 3 ☐Re	emoval from State cemetery	Disposition (Name of crematory or other plan	1		20c. Location - City or	Town, State
Ħ	permit. Page Department Important: It any injury or once.		4 □Donation 5 □Other (Specify) 21. Signature of Emeral Service License	METROPOLITI MO0479				ALEXANDR	IA, VA
<u>~</u>	Deg imp gang		Muhale	0.X	RAYMOND LA PLAT			CE, P.A. 0646	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause en each line.			or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence or	e Injus	ies			
ı	Examiner	-	Sequentially list conditions, b	Due to (or as a consequence of	Se .				
′	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
68760,	ficate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or as a consequence of	i):				
687		ledical							
P.O. Box	The law requires that the death certi site has been signed by the ettending page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pregnance 5 ☐ Other (specify) _	/		23d. Date of de Month	livery Day Year
<u>ر</u> ت	res that the de signed by the e be detached f	by Ph	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause giv	ren in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
ords	w require been sig should b						1 🗆 Y	es 2.0XNo 3.□P	robably 4 Unknown
		Completed					24a. Was a autops perform	sy prior to med? deal?	utopsy findings available completion of cause of
Vita	ystcien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:	ostiont 30 DOA Ott	000	th Check only or	- 1	
o	\$ 5 E	ը :	27. Manner of Death	28a. Date of Injury 28b. Ti	me of 28c. Injur	4 Nursing n	ome 5 Residence 28d. Describe he	ow injury occurred	•
sion	eath. or: After the funer	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		SL AL 10	Yes 2 No	Ejecta	d passing	collision
Ö	2 = -	Certification;	4 Homicide determined	28e. Place of Injury · At home, fam building, etc. (Specify)	m, street, factory, office		City or Town	treet and Number or A n, State) 9100 T Plata 141	wral Route Number. Whey thill Rd
	To the Hospitel of within 24 hours el To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination	ician: To the best of my knowledge, ler: On the basis of examination and and manner stated.	death occurred at the tid or investigation, in my o	me, date and place opinion, death occu	, and due to the c irred at the time, d	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier		29c. Licens	se number	2	29d. Date signed (Mon	th, Day, Year)
•	,			lanus	OCI	Œ		March 31,	2006
	6		30. Name and address of person who con	(ATI)-111-1	. 111 Per	n Street	Baltim	ore, Maryl	and 21201
** ga	Sta Registr		31. Date filed (Morph PR. Par7 20	06 32 Fegistrar's Signative	goode				-

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** WILMA DRUSCILLA DORSEY PLATER March 20, 11:58P M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Civista Medical Center La Plata Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 ₩ F Yrs. Director 212-66-4935 50 FEBRUARY 28, 1956 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or iteme 23e or 28e-f show other traumatic event. Its Madical Examiner must be notified at 1 □ Yes 2 🛱 No Director MARYLAND CHARLES WICOMICO / CHARLOTTE HALL 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 12230 PLATER ROAD 20622 UNITED STATES Funerai 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12TH GRADE HOUSE CLEANER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental } JAMES MILTON HICKS MARY RITA DORSEY HICKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau CHARLES L.C. PLATER, JR./HUSBAND 12230 PLATER ROAD, CHARLOTTE HALL, MARYLAND 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ST. MARY'S CHURCH CEM, MARCH 27,2006 NEWPORT, MARYLAND ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funéral Service ConseqUADIA C. THORNTON JOHN THORNTON JOHNSON MO0583 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Que 2 m /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and рө өхөс Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. nding physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant atter 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Year Month 4□Pregnant at time of death 5 Other (specify) ed by the a detached for ☐Yes 2 ☐ No 9 Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes of or Attending Physicien: after death. Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 1 Natural 5 Pending investigation M 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and panner, state(s). 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D-02975 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel M. Howell, MD 11345 Pembrooke Square, Ste. 104, Waldorf, Maryland 20603 32. Paistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 4 2006 Registra

State of Maryland / Department of Health and Mental Hygiene] Certificate of Death

-	0	0	7	
å	U.	J	ď	C

			1 = For State Registrar	State of M	arylari	-	rtificate			ti iu ivi		eg. No.	UUD	1 U	310
1864 1	Physic	an	Decedent's Name (First, Middle, Ann Teresa P	Last) iety							2. Date of Dea Month March	Day	2006	r	ime of Death
	/Medi Examir		4a. Facility Name (If not institution,)		4b City	Town or	Location o	f Death	March		County of De		:54 p M
	Examili	iei	Holy Cross Hos						Sprin				ntgome		
\$1	Funeral	1	Social Security Number		ge (In yrs. i	last birthday)	If Under Months		If Under 2	24 Hrs. Min.	8. Date of Birth	Vearl	9. B	irthplace (S	State or Foreign
	Director		213-78-0950	1 □ M 2 ☐ ¥F	46	Yrs.	Months	Days	Hours	MIII.	8. Date of Birth (Month, Day April 2	7, 1	.959 Ca	ilifo	rnia
111	and *		Usual Residence of Decedent 10a, State 10b, County		10c City	y, Town or Lo	cation							10d Inc	side City Limits
	Aaryli sho	ō		70-411				_							Yes 21 No
	28a-	rect	Maryland Montgon 10e. Street and Number	nery	51	lver S	10f. Zip					On Citi	zen of What	Country?	
	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-18 show among in purpor other traumatic event. Its Madical Examinating must be published at once.	by Funeral Director	402 Hillsboro D	rive			10	2090	02			og. o	US	•	
	death	era	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. \	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - An	nerican Ind	ian,
9	or ite	F	1 X Never Married 2 ☐ Marrie	Armed Forces						, Puerto F	Rican, etc.)		Black, W		
03	ral',	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	LXI No	Specify:				Specify: Wh	iite	
21215-0036	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	kind of won	k done o	lurina most	of working	ng	16b. Kir	nd of Busines	ss/Industry	
121	vithin ne. han	шp	Elementary/Secondary (0-12)	College (1-4or 5+	5+)	life. I	DO NOT us	e retired,)						
	Hygie Hygie ther t		17. Father's Name (First, Middle, La			VE	eterin	arı		r's Namo	(First, Middle,		erinar	у Мес	dicine
Maryland	antal h	Be	Lewis G. Piety	(31)							yn Tala!		Sumame)		
2	hould Me Id	၉	19a. Informant's Name/Retationship	(Type Print)		19h Mailin	a Address	(Street o			Route Number		Tour State	Zin Codo	
<u>≅</u>	nd 2 s lith ar 27 is 27 is		Marilyn Talabay		ther						Silver			. ,	
ē,	tem tem other		20a. Method of Disposition	/ Ilecy/ No	20b. P	lace of Dispo	sition (Nam	e of		D	ate		cation - City of		
e E	Page 11 of 1		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Gate	emetery, cren e of Hea	ven Ce	meter meter	⁹⁾ [M	iarch 20		ilv	er Spr	inα.	Maryland
Baltimore,	natt.		21. Signature of Funeral Service Lie	••							Funera				riar y raira
ä	De la la la la la la la la la la la la la		Doing 2 Si	li		5	ranci 00 Un	s J. ivei	. Coll rsity	lins Blv	Funera d. W, S:	l Ho ilve	me Inc r Spri	ng, N	4D 20901
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that cause	d the death	. Do not ente	er the mode	of dying	g, such as o	cardiac or	respiratory arr	est,		Appro	oximate ral Between
	Physician		Immediate Cause (Final disease or condition	Status		atics								Onse	t and Death
1	/Medical		resulting in death)	Due to (or as										-	, u. j
	Examiner		Sequentially list conditions.	Chronic										Dec	adem
	be sit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duá tô (ôr ás	a consequ	rence of).									
	death certificate be executed e attending physician and at for use as the burial-transit	хаш	that initiated events resulting in death) Last	c. Due to (or as	2 000000	ionos of):									
68760,	be ey	al E		Due to (or as	a consequ	ience ot):									
387	phys the	Medical	<u> </u>	d.											
×	certif nding ise a:	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncv							2d Data of d	alise a s	
Вох	death cer attendin	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a	2 Fetal	death 3	Ectopic pre						3d. Date of d Month	Day	Year
0	that the de ned by the a detached f	Physician/N	9 Unknown	9□ Unknown											
٥.	The law requires that the ate has been signed by th bage 2 should be detache	by PI	Part II. Other significant condition	s contributing to death b	out not resu	Ilting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	acco u	se contribute	to the caus	se of death?
rds	quire in sig uld b	d be	History of Depre	esssion							1 🗆 Ye	s 2[34 No 3 🗆 I	Probably	4 Unknown
Records,	s been s been s shouk	Completed									24a. Was a	n	24b. Were	autopsy fin	dings available
Re	The la te ha	mo									autops	ned?	prior to death?	completio	n of cause of
Vital		o o	25. Was case referred to medical						26 Place	of Death	(Check only on		1 L2-Y6	s 2□N	0
<u> </u>	Physician: The law this certificate has lared director, page 2 s	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	ent 210	ER/Outpatien	3 DO	Othe			e 5 ☐ Reside		Other (Sc	ecify)	
	O = 0		27. Manner of Death 1 ⊠Naturat 5 □ Pending	28a. Date of Inju	iry V Year)	28b. Time of Injury	28	c. Injury Work			8d. Describe ho				
<u> </u>	Attending r death. ector: Atter by the tune	atic	2 ☐ Accident investigat	ion	,	,,	М		es 2□N	ło					
Division	l or Atteno after deatl Director: I in by the	Certification;	3 Suicide 6 Could no determine		ury - At ho	me, farm, stre	eet, factory,	office		2	8f. Location (St City or Town			Rural Route	a Number,
	spital cours at neral D		00.00												
	To the Hospital within 24 hours a To the Funeral C	Medical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of	f examinat	vledge, death ion and/or inv	occurred a restigation,	it the tim in my op	e, date and inion, death	f place, a	nd due to the ca	ause(s) ate and	and manner and di	as stated. ue to the ca	iuse(s)
	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner st	ated.			License					signed (Moi		
	F 3 F 8						200.	-1241130			-	Ju. Dale	, signed (MU)	, Day, 1	VM1/

Steven T. Kariya, M.D.

31. Date filed (Month, Day, Year)
MAR 2 3 2006

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

32 Registrar's Signature

29c. License number

D36252

11501 Georgia Avenue, #515, Wheaton, MD 20902

March 20, 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State	of Maryla	and / Dep <i>Ce</i>			lealth and Death	d Mental		ene 0 0	0	10978
ı	* 3 3		1. Decedent's Name (First, Midd.	le, Last)		-				2. Date Mont	of Death	Day	Year	3. Time of Death
	Physicia /Medic		Julia Barnum	Roberts							h 21		Todi	6:30 p M
1	Examin		4a. Facility Name (If not institution	n, give street and n	um <i>ber)</i>		4b. City	, Town, or	Location of D	eath		4c. County	of Death	
			Manor Care					aton				Montg		
\$ 2.	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21K F		rs. last birthday,	If Und	or 1 Year Days	If Under 24 h	vin. (Mon	of Birth	(ear)	9. Birth Cou	place (State or Foreign ntry)
3	Director		558-32-9037	16.111	86	Yrs.				May	20,	1919		Idaho
	and w	1	Usual Residence of Decedent 10a, State 10b, County	,	10c.	City, Town or L	ocation							10d. Inside City Limits
	Aaryl Fehc	5	D.C. Non	0	Wa	shingto	n							1 ∰Yes 2 □ No
	the I	Director	10e. Street and Number		***	BIIIIIGCO		ip Code			100	. Citizen of W	/hat Cou	intry?
	hours after death with the Maryland tural; or Iteme 23a or 28e-f show al Exemple at must be notified at		5330 Nebraska A	wo N U				20015				U.S.A.		,
	ne 2:	Funeral	11. Marital Status	12. Was De	cedent Ever in	n U.S. 13.	Was Dec	edent of H	ispanic Origin?	? (Specify Yes	or No-	14. Race		can Indian,
0	r Iter	Ē	1 ☐ Never Married 2 🔀 Mar		2€ No					uerto Rican, et	c.)		k, White,	_
2	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or	live Dates:		1 🗌 Yes	2LX No	Specify:			Specify.	: Wh	ıte
213-0036	72 hc	Completed	15. Deceder	nt's Education	()	16a. Dece	dent's Us	ual Occup	ation during most of	workina	16	b. Kind of Bu	siness/Ir	ndustry
N	ithin	nple	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT	use retired	1)					
Z	ygier ygier ther th	Co			5+	Libra	rian	/ Mu	sic Tea			Educat:		
/iand	be fill	Be	17. Father's Name (First, Middle,							Name (First, N			θ)	
3	f Mer nark natic	၉	G. William Bar			105 14-11		(0)		Sophia			C4-4- 7:	. 0- 4-1
<u> </u>	12 st h and 7 ts n traun		19a. Informant's Name/Relations				•	,		r Rural Route f				
_ ຍົ	1 and Healt em 2 ther		D. Ellis Rober 20a. Method of Disposition	ts / Hus	band	b. Place of Disp	osition (Na	ame of		NW Was		c. Location -		
פַ	M I I		1 ☐ Burial 2 X Cremation		n State	cemetery, cre	matory or	other plac		25 200			•	
sanimore	urtment ortant		4 ☐ Donation 5 ☐ Other (5		N	lational	Cre	nator	y 3-	-25-200 Joseph	$6 \mid F_3$	alls Ci	nurc	h, Virginia
ğ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28e-f show any injury or other traumatic event, the Mudical Exemple Indiffice at once.		Tan Oru	600	sores									C 20016
			23a. Part1. Enter the disease, o		caused the d								1, 5	Approximate
			shock, or heart failure. List fmmediate Cause (Final	only one cause on	each line.									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Ca	Corasa con	o-Res		ar	org	477	5/			
	Examiner			CO	Ronn	sequence of): y x x x x x x x x x x x x	-10	-0	dist	918				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a cons	sequence of):	0							
	outed Id	Examiner	Cause (Disease or injury that initiated events	S .										
o Î	en ar		resulting in death) Last	Due to	o (or as a con	sequence of):								
8/60,	cate be executed physicien and the burial-transit	dicai		d										
٥	2 0 a	Med	IF FEMALE:											
X O D	death certifi e attending I ad for use as	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pre birth 2 TF	Fetal death 3 (pregnancy				23d. Date Mor		rery Day Year
- -	the a	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Preg 9□ Unk	gnant at time (nown	of death 51	Other (specify)						,
7.	w requires that the death cer been signed by the attendin should be detached for use		Part If. Other significant conditi	ons contributing to	death but not	resulting in the u	ınderlyina	cause div	en in Part I.	23e.	Did toba	cco use contr	bute to	the cause of death?
g,	sign d be	d by	demention	4 4 1		-					1 🗌 Yes	2 100	3 ☐ Pro	bably 4 Unknown
CO	v requ	ete	1.2.1			- //				740	Was an	74b V	More aut	opsy findings available
Ž	has has	Completed								_ 24a.	autopsy	_ p	rior to co	ompletion of cause of
	ician: Th certificate rector, pag	င်	05 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\								Yes 2	No 1	Yes	2 No
VItal	Physician: this certific ral director,	00	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	2 DER/Outpatie	nt 3□ [Oth		Death (Check		2 COtt		Z. A
Ö	Phys	. To	27. Manper of Death	28a. Date	e of fnjury	28b. Time o		28c. Injun Wor				injury occurr		ny)
0	ding f th. : After s funer	tio	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Mo igation	nth, Day Yea	r) Injury	М		k? Yes 2 □ No					
UNISION	after death. I Director: After	Hice	3 Suicide 6 Could 4 Homicide determ	nined 288. Plac	ce of Injury - A	At home, farm, st	reet, facto	ry, office					er or Rur	al Route Number.
5	0 4 5 E	Certification;	4 Homicide	buil	ding, etc. (Sp	өспу)				City	or Town,	State)		
	ospit hours uners ly fille	sai (29a. Certifier Certifyi	ng Physician: To the	ne best of my	knowledge, dea	th occurre	d at the tin	ne, date and p	lace, and due t	o the cau	se(s) and ma	nner as	stated.
	To the Hospital within 24 hours a To the Funeral C completely filled	edical	(Check only 2 Medical one)	Examinar: On the and ma	basis of examinner stated.	mation and/or in	rvestigatio	ırı, ın my o	pinion, death c	occurred at the	time, date	e and place, a	ina due l	to the cause(s)
	To To moo	Σ	29b. Signature and title of certific	1 /-	10	11		9c. Licens			290	I. Date signed	(Month,	Day, Year)
9			· I / / CC	m	1	14.		NO	10553	62	0	3-2	c - c	6
1.5	2		30. Name and address of person	who completed car	use of death (Item 23a) (Type	Print)	/ Ri	LA SE-	eya 1	1.0	Kai:	ser	permonate
Jo		1.00	31. Date filed (Month, Pay, Year MAR 2	regges	Registrar's Si	ignature R	Och	VIE	ce M	20	85 6			
	Sta	7.3	31. Date med (Month Day, 1981	32.	megistrars Si	igriatul 8	1 1.0							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Month **Physician** Doris Evelyn March 22, рм 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5901 Montrose Road, #C-205 Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 15, 1921 North Carolina 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2 F 241-22-1011 84 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rai', or iteme 23a or 28a-f show Examinational by notified at 1 Yes XX No Maryland Montgomery Rockville Direct 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5901 Montrose Road, #C-205 20852 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Copartment of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or Itel injury or other traumatic event, the Mudical Examples one. 1 Never Married 2 Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Specify:White Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Head Bookkeeper Research 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) L. M. Stanley Sallie Creel 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony D. Retos/ Husband 5901 Montrose Road, #C-205, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March 27, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Faison Cemetery 2006 4 ☐ Donation 5 ☐ Other (Specify) Faison, North Carolina 22. Name and Address of Facility ins Funeral Home Inc. Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee 4 avus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Endometrial Cancer unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury b. Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. | 1 ☐ Yes 2X No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 s autopsy performed? 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🛂 No 2 1 Inpatient 2 ER/Outpatient 3 DOA : After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death 1 ☐ Yes 2 ☐ No 2 Accident after death the 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cai 29a. Certifier (Check only onel and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D34726 March 23, 2006 Nette m.0 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jasmine Chen Gatti, M.D. 8218 Wisconsin Avenue, #302, Bethesda, MD 20814

State Registrar 31. Date filed (Month, Day, Year)
MAR 2 4 2006





10980 d Mental Hygiene

. For	State of I	Maryland / Department of Health and
1 - State Registrar		Certificate of Death
1. Decedent's Name (F	îrst, Middle, Last)	

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

*To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	-	1 - State Registrar	,	C	Certifica	ate of	Death	Reg	. No.	\$ 1905 637 700 100
		1. Decedent's Name (First, Middle, La						2. Date of Death Month	Day Year	3. Time of Death
icia dica			Esther Ber	necia	RUBEN			March 20	,	10:07 A M
nine		4a. Facility Name (If not institution, giv	re street and number)		4b. Ci	ty, Town, o	r Location of Deat		4c. County of De	
		Holy Cross Hospi	tal		S	ilver	Spring		Montgom	erv
al		5. Social Security Number 6. S	_ 37	yrs. last birth		der 1 Year				irthplace (State or Foreign Country)
or		000-22-3377	1 □ M 2 🛣 F	80 Yr	's.			Jan. 17,	l N	ew York
	-	Usual Residence of Decedent 10a. State 10b. County	100	City, Town	or Location			,		10d. Inside City Limits
	2									1 ☐ Yes 2 🖫 No
	Director	Maryland Montgon 10e. Street and Number	ery	Silver		1g Zip Code		100	. Citizen of What 0	
			- L		101. 2	Zip Code				
	Funeral	1220 East West Hi	12. Was Decedent Ever i	nlls	13 Was De		910 Jenanic Origina (9		nited St	ates nerican Indian.
,	Ş	1 Never Married 2 Married	Amed Forces?	., 0.5.	If Yes, s	pecify Cuba	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Black, Wh	
	<u>~</u>	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes	2 X No	Specify:		Specify:	white
	Completed	15. Decedent's E			ecedent's U			16	b. Kind of Busines	s/Industry
-	e l	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	- (G	ife. DO NOT	use retired	during most of wo d)	rking		
	0		2	W	ard Se	creta	iry	0	ld Soldi	ers Home
	e n	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, Ma	iden Sumame)	
	0	Jo	seph Savitsky	7			Rose	Smerin		
		19a. Informant's Name/Relationship (Type, Print)	19b. A	Mailing Addre	ss (Street	and Number or Ri	ural Route Number, C	city or Town, State,	Zip Code)
		Leonard Koenick,	Attorney	545	4 Wisc	onsin	Ave., (Chevy Chas	e, MD 20	0815
B		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐	1	 b. Place of D cemetery, 	Disposition (A crematory o	iame of r other plac	ce)	Date 20	c. Location - City of	r Town, State
		4 □Donation 5 □Other (Special		Judean	Memor	ial G	ardens (3/23/06	Olnev M	5
ouce.		21. Signature of Forest September Lice	nsee		22. Name	and Addres	ss of Facility	Funeral H	15.50	
ä										20012
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the d	leath. Do no	t enter the m	ode of dyin	g, such as cardia	c or respiratory arrest	geon Lo	Approximate Interval Between
an	1	Immediate Cause (Final disease or condition	Description	O			. 1			Onset and Death 8 Years
al		resulting in death)	a. Progressiv Due to (or as a con	sequence of)	ranucı :	ear b	alsy			
er		Sequentially list conditions	b. ———————							
	l e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of)):					
	Examiner	that initiated events	с							
		resulting in death) Last	Due to (or as a con	sequence of)):					
	Medical	•	_ d							
	Me	IF FEMALE:								
	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death	3 □Ectopic		,		23d. Date of d Month	elivery Day Year
1	3	1 ☐ Yes 2√ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	of death	5 Other	(specify)				,
2	Completed by Physician	Part II. Other significant conditions	contributing to death but not	resulting in th	he underwing	a cause and	on in Part I	23e Did tobar	co use contribute	to the cause of death?
	2	Hyponatremia	ioning to doubt out not	rosannig ar a	no underlying	g cause giv	on in a dit i.	1 ☐ Yes		Probably 4 Unknown
	i eie	J. L. L. L. L. L. L. L. L. L. L. L. L. L.					-			
								24a. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
								performe 1 ☐ Yes 2 ☐		s 2□No
10	ם ו	25. Was case referred to medical examiner?	Hospital:			0#		ath (Check only one)		
	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 X Inpatient 2	2 ☐ ER/Outp			1 110151119	lome 5 ☐ Residence		ecify)
		1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	r) 28b. Tin Inju	ıry	28c. Injun Wor		28d. Describe how	injury occurred	
	Ca	2 Accident investigatio 3 Suicide 6 Could not b	00- 01 41	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	M		Yes 2 □ No	206 Leasting (Street	A and Always and	2
	Certification;	4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	ecify)	i, street, racti	ory, office		City or Town, S		Rural Route Number,
0	2	29a. Certifier 1 Certifying Ph	nysician: To the best of my	knowledge	feath accura	nd at the f	no date and also	and due to the		no stated
	medical	(Check only 2 Medical Examone)	niner: On the basis of exam and manner stated.	nination and/	or investigation	on, in my o	pinion, death occu	rred at the time, date	and place, and du	is stated. ie to the cause(s)
	3	29b. Signature and title of certifier			2	9c. License	e number	29d	Date signed (Mor	nth, Day, Year)
		•	7							
	-	30. Name and address of person who	completed cause of don't	1/V	ma Pries	D 52	503 (MD)	<u> </u>	March 20,	2006
		Shailesh Sheth,			, , ,	o a d	Silver S	nring MD	20910	
State		31. Date filed (Month, Day, Year)	32 Registrar's Si	gnature	Accept.	,	STINCT D	hrang an	20310	
stra			006	15 1	1000					

Registrar

06-2006 B.K.S JEOVANNY RODRIGUEZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

L	epariment	OLL	leallii	anu	Mentai	1
	Certificate	of	Death	7		

		•	For State Registrar	Cer	tificate of Death		3. No.	0981
	Physicia		Decedent's Name (First, Middle, Last) Jeovanny	Rodrigue	· Z	2. Date of Death Month MARCH	Day Year 21, 2006	3. Time of Death 4:25 P M
Ž	/Medic Examin		4a. Facility Name (If not institution, give st PRINCE GEORGES HOS		4b. City, Town, or Location of Death CHEVERLY	4	4c. County of Death PRINCE	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) M 2 F 1 Yrs.	If Under 1 Year II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign ntry) ryland
	D	lor	Usual Residence of Decedent 10a. State 10b. County MD Prince	George's Hyatts				10d. Inside City Limits 1 ☐ Yes 2 X No
	s with the	i Direc	10e. Street and Number 5114 Kenilwort	h Avenue #10	10f. Zip Code 20737	10	g. Citizen of What Cou	ntry?
036	2 should be filed within 72 hours after death with the Maryland and Mendal Hygiene. Is marked other than "neturel", or Items 23a or 28a-f ahow aumatic avant, the Modical Examinar must be notilised at	by Funeral Director	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 KNo	Was Decedent of Hispanic Origin? (S 1Yes, specify Cuban, Mexican, Puert 1⊈Yes 2□ No Specify: El Salvac		14. Race - Amer Black, White Specify: W	
21215-0036	within 72 ho ene. than "netur the Modical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+) 16a. Decec (Give life. I	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) NONE	king	6b. Kind of Business/II none	ndustry
land 2	d ta b	To Be Co	17. Father's Name (First, Middle, Last) Osmar Rodriguez	,		ne (First, Middle, Mi La Sovia		
Maryland	5 € Z ±		19a. Informant's Name/Relationship (Type Osmar Rodriguez		ng Address (Street and Number or Ru 1 Kenilworth Av	ral Route Number, 7e.#10 H	yattsvil	le,Md
Baltimore,	Pages 1 and nent of Heel and in If Itam 2 ary or other		20a. Method of Disposition 1 Spurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	sition (Name of natory or other place) E Heaven 3/25		oc. Location - City or 1 Silver Sp	own, State
Baltii	permit. P Depertm Importar any inju		21. Signature V juneral Service L cerse	9/) · Pi	HILTP ABORTNALD 241 Columbia B	FUNERA	L SERVIC	E,P.A.
	Pnysician /Medical Examiner	9.	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Stations that caused the death. Do not enter cause on each line. Should Thurst Due to (or as a consequence of):		- 7	yery	Approximate Interval Between Onset and Death
68760,	The law requires that the death certificate be executed ate has been signed by the ettending physician and page 2 should be deteched for use as the burial-transit	Medical Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
.O. Box 6	at the death certifi by the ettending (teched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)		23d. Date of delin	very Day Year
₾.	uires that n signed by id be dete	ρ	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
I Records,	The law require ate has been single 2 should be	Completed				24a. Was an autopsy perform 1 Yes 2	prior to c	opsy findings available ompletion of cause of
Vita	Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 3,5, ER/Outpatier	Other	ath Check only one	nce 6 ⊡Other (Spec	ufu)
Division of Vital	ding Afte fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 3 Z	f 28c. Injury at Work?	28d. Describe hos	w injury occurred	1.
Divis	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, larm, str building, etc. (Specify)	1	City or Town,	eet and Number or Ru State) 5114 kg Onston, MD F	aulworth Her.
	s Hospi 24 hou s Funei letely fill	Medical		iician: To the best of my knowledge, deat ler: On the basis of examination and/or in and manner stated.				
)	To the To the compl	Me	29b. Signature and title of certifier	M	29c. License number O.C.M.E	29	nd. Date signed (Month	2, 2006
	•		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, 111 PEN	Print) N STREET, BALTIMO	ORE, MARYIJ		
		1	10.110017					

State Registrar 31. Date filed (Month, Day, Year) MAR 2 3 2006

32. Registrar's Signature

			For State Registrar	State of M	laryland	-	artmen rtificat			nd M		giene Reg. No.	006	al-minufflorends	098	2
	Physici	an	1. Decedent's Name (First, Middle, Las Eleanor Margare	_	tson						2. Date of Da Month March		2006	ar	3. Time of De	
	/Medio	al	4a. Facility Name (If not institution, give				4b City	Town or	Location of	Death	March		County of E)eath	1:00 a	iAI
	Examir	er	622 Mississippi		,				Spri				Mont		ry	
	Funeral	- 100	5. Social Security Number 6. Se	7. A	ge (In yrs. las	st birthday)	If Under		If Under 24		8. Date of Bird	th Veer	9.	Birthpla Countr	ce (State or Fo	oreign
R.	Director		5//-14-3246	□м 2🖺 F	89	Yrs.	Months	Days	Hours	IVIIII.	Jan. 2	6, 19	917 Wa	ashi	ngton,	DC
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	cation							10	d. Inside City L	imits
	Maryli f sho	ō				ehiqh		C							1 Tes 2	
	r 28a	rec	Florida Lee 10e. Street and Number			enign	10f. Zip					10g. Citiz	en of Wha	t Countr	y?	
	th with	aiD	519 MacArthur Av	zenue			339	36				Ţ	JSA			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f ahow amy injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?		Was Deced If Yes, spec 1 ☐ Yes		spanic Origin, Mexican, Specify:	in? (Spe Puerto I	crfy Yes or No Rican, etc.)	1	4. Race - A Black, V W Specify:	White of	ic.	
5	72 ho	eted	15. Decedent's Ed (Specify only highest grad			16a. Dece	kind of wo	rk done d	urina most c	of workii	na		d of Busine		•	
2	han a	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT us	e retired,					_		& Thea	ter
75	Hygie Hygie Ither t		17. Father's Name (First, Middle, Last)	3	-	Secr	etary	/Tre	asure:		(First, Middle,		hting	9		
Maryland	ould be f Mental I arked of atic eve	To Be	Grover Harris						Elear	nor	Marie	Harde	sty			
, Mar	and 2 sh salth and n 27 Is m		19a. Informant's Name/Relationship (7 Eleanor Wilder/ [Route Number Road,					56
Baltimore,	nent of He		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify		cen	ce of Dispo netery, crer r Hill	natory`or o	ther place) M	arcl 200	1 ^{ate} 24,		ation - City .and ,		n, State	
Balt	Departi Importi any ini		21. Signature of Funeral Service Licen	500 Ocol		F 5	ranci 00 Un	gadges iver	sity l	ins Blvd	Funera l, W, S	l Hon ilveı	ne Ind	ing,	MD 20	901
	Physician		23a. Part1 Enter the disease, or comp shock or heart failure. List only of fmmediate Cause (Final disease or condition	blications that cause one cause on each Bronch	line.				, such as ca	ardiac o	r respiratory a	rrest,			Approximate Interval Between Onset and Dea	ath
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ <i>e</i>	nce of):										
) B	ted sit	Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	b. Ona to (or se	s nonseque	nes ofly:										
8760,	icate be executed physicien and s the burial-transit		that initiated events resulting in death) Last	Due to (or as	s a conseque	nce of):										
9	ng ph	Medi	IF FEMALE:												**************************************	
.O. Box	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be deteched for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant a 9 Unknown	2 ☐ Fetal d	eath 3	∃Ectopic pr ∃ Oth <i>e</i> r (sp					2:	3d. Date of Month		∕ Day Y <i>e</i> a	,r
<u> </u>	ires that the de signed by the a d be deteched f	by	Part fl. Other significant conditions co	ontributing to death	but not result	ing in the u	nderlying c	ause give	n in Part I.		-				cause of deat	
COL	w require	iete									24a. Was	an	24b. Were	e autoos	sy findings ava	ulabl <i>e</i>
of Vital Records,	n: The law icate has r, page 2 a	Completed									autor perfo 1 Yes	osy rmed? 2 X No	prior deat 1 🗆	to com	pletion of caus !□ No	e of
Ξ	Physician: this certificatal director, i	o Be	25. Was case referred to medical examiner? 1 Yes 25 No	Hospital: 1 ☐ Inpat	200	R/Outpati <i>e</i> r		Othe			<i>(Check only o</i> ne 5□Resid		TO: (Seconda	arv
	ding Phy h. After this funeral d	⊢ ⊦	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Inj (Month, D	ury 2	8b. Time of Injury		8c. Injury Work	4 🗀 Mui 5	2	28d. Describe I			<i>Бреспу)</i>	Resider	ice-
Division	al or Attending Physician: The after death. I Director: After this certificate his d in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	ijury - At hom tc. (Specify)	e, farm, str	eet, factory			-	28f. Location (3 City or Tou		Number o	r Rural	Route Number	,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	edical C	29a. Certifier Check only one)	ysician: To the bes iner: On the basis and manner s	of examinatio	edge, deatl n and/or in	h occurred vestigation,	at the tim	e, date and inion, death	place, a	and due to the ed at the time,	cause(s) a date and	and manne place, and	r as sta due to t	ted. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				290	License					signed (M			
	20		30. Name and address of person who	completed cause of	death (Item 2	3a) (Type	Print)	D59					h 21,			
100.2			30. Name and address of person who on Dawn Marie Christ 31. Date filed (Month, Day, Year)		D 103			Ave	nue,	#203	3, Silv	er Sp	ring	, MC	20902	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 23 20	106	N S	A	seles									

			1 - For State Registrar	State of Ma	ryland		artmen rtificat			and M	-	giene Reg. No	_ U U I	in.	10983	
			Decedent's Name (First, Middle, Last)					-			2. Date of De	ath			3. Time of Death	
	Physici /Medio		Mohamed Ali	Mugbil	Soa	rkati					$\frac{M^{onth}}{3}/2$	4 7	³ 2006 [°]	eer	3:00 a	A
>	Examir		4a. Facility Name (If not institution, give	street and number)	_		4b. City,	Town, or	Location of	of Death		40	. County of	Death		_
			Holy Cross Hos	pital			Sil	ver	Spr	ing		M	lontg	ome	ry	
	Funeral Director		5. Social Security Number 6. Security Number 1X	7. Age	(In yrs. la	ast birthday) Yrs.	If Under Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of Bird (Month, Da 4/23/	v. Year)	Birtho	place (State or Foreign htry) an	n
	DC		Usual Residence of Decedent 10a. State 10b. County		10c City	. Town or Lo	eation								Od Inside City Limite	
	aryla shon	-	,												10d. Inside City Limits 1 ☐ Yes 2X No	
	Ne N	ect	Md. montgome	ry	Sil	ver	Spri					10- 0	itizen of Wha			
	death with the Maryland ms 23a or 28a-f show froust be notilited at	급		Dl	1 401		10f. Zip							at Cou	ntry ?	
	eath	erai	1131 University	12. Was Decedent E				902	nanic Orig	nin? (Soc	ecify Yes or No		udan 14. Race -	Amari	ean Indian	
	ter d	by Funeral Director	1 Never Married 2 X Married	Amed Forces?		10.1	f Yes, spe	cify Cubar	, Mexican	Puerto	Rican, etc.)		Black,			
38	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 \(\bigcirc\) No	Specify:				Specify:	bl	ack	
5-0036	2 hou	Te d	15. Decedent's Edu	cation		16a. Deced	dent's Usu	al Occupa	tion			16b. F	Cind of Busir	ness/In	dustry	_
215	within 72 ene. then 'nai	Completed	(Specify only highest grade	College (1-4or 5+		(Give life. l	kind of wa DO NOT u	ork done d se retired)	uring mosi	of worki	ng					
2	d wit	E O	Zionianiary/occorridary (o 12)	4		unem	ploy	red				n	one			
פ	e file al Hy oth	Bec	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,					
aryland	uld b Menta	2	Mugbil Soarkat	i					Ata:	ia	Elgma	al				
au	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "nature!, or Items 23a or 28a-f show many injury or other traumatic event, the Medical Examiltational be notified at ance.	d i	19a. Informant's Name/Relationship (Ty	*		19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	l Route Numbe	er, City	or Town, Sta	ate, Zip	Code)	1
Σ	and salth		Yassir Mugbil	/son	, , ,	5601	Sem	inaı	ry Ro	d.,#	2617	Fal	ls Ch	ur	2204 ch, VA	1
altimore,	OF FEE		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R	emoval from State	20b. Pl	ace of Dispo	sition (Name	me of other place)	C	ate	20c. L	ocation - Ci	ty or To	own, State	
Ĕ	Pages ment of I		4 Donation 5 Other (Specify)	emovarnom State	Far	nily				3/28	1/06	Kh	artou	ım.	Sudan	
ä	pparti porti iy in		21. Signature of Funeral Seprice License			22	. Name ar	nd Address	s of Facilit	Uni	versa	l M	ortua	ry		
m	99 E 2 9		1 milles	~ OE	54	4	11 K	enne	edy S	st.,	N.W.	Vas:	hingt	on	,DC 2001	1
	Physician		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line	ð.					cardiac o	r respiratory ar	rest,			Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as a	consequ	ence of):	ile	ure	4						uus.	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Seps	consequ	enlee of):									ueus.	
8760,	cate be executed oblysician and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a		ence of):	us	6	acr	erc	ae f	er	Hom;	41	cieles	
68	tificate ig physi as the t	edi														
Вох	death certifi e attending p id for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o	Fetal	death 3	Ectopic p						23d. Date of		ery Day Year	
o.	by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at ti 9☐ Unknown	me or de	ath 5L	Other (sp	овсту)								
٥.	The law requires that the ate has been signed by th bage 2 should be detache	4	Part II. Other significant conditions con	tributing to death but	not resu	Itina in the ur	nderlyina d	ause dive	n in Part I.		23e. Did to	obacco	use contribu	ute to t	ne cause of death?	
Records,	signed by d be det			ū		•	, ,					es 2		Prob		1
ŏ	w require been sig should b	Completed			-						24 146		-	-		_
ě	e law has	E G									24a. Was autop		24b. We prio dea	re auto r to co	psy findings available mpletion of cause of	3
-												20 No		Yes	21 No	
Vital	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	lospital:				Othe	-		Check only o	- 1				-
ō	Phys rthis raldi	T	1 Yes 2 No	28a. Date of Injury		R/Outpatien 28b. Time of		77	4 🗆 140		ne 5 Resid			(Specif	y)	_
5	ding for	Ē	1-Natural 5 Pending	(Month, Day	Year)	Injury	м	28c. Injury Work	? 'es 2 []!	,	EGG. Describe i	iow inju	ity occurred			
Division of	Attending Physician: It death. ector: After this certific by the funeral director.	fica	3 Suicide 6 Could not be	28e. Place of Injur	v - At hor	me farm str			V3 Z []		28f Location (S	Street a	nd Number	or Rus	d Route Number,	-
<u>></u>	s after al Dire ed in b	Certification;	4 ☐ Homicide determined	building, etc.	(Specify))	soi, lactor	y, onice			City or Tox	vn, State	e)	or riure	arroute rumber,	
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sicien: To the best of ner: On the basis of e and manner state	examinati	vledge, death on and/or inv	occurred restigation	at the time, in my op	e, date and inion, deat	d place, a	and due to the e	cause(s date an	s) and mann d place, and	er as s	tated. the cause(s)	
	withir To the comp	Me	29b Signature and title of certifier					c. License					ate signed (/			
			A. NAW	1//			1)50	98:	F.		3	-24	1-1	36.	
	3		A. NAW TO Name and address of person who co	mpleted cause of de	ath (Item	23a) (Type.	Print)				. 1				27. 2	_
		4	AHMED NAWA	2 MD F	DB	0x 8	381	9 9	ail	ner	soure	מ	כ פח	108	SS >	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar	's Signati	ure do	well !									

State of Maryland / Department of Health and Mental Hygiene 🗎 🦰 🦰 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8:48A M 20, 2006 4c. County of Death RUTH SHAW March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Olney Montgomery Montgomery General Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☐ M 2 🕱 F 058-12-5742 85 Nov. 24, 1920 New York Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 238 20906 U.S.A. 14510 Homecrest Road Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 ō 1 Yes 2 XNo Specify Specify: White 3X Widowed 4 □ Divorced 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Medical Secretary Private . Pages 1 and 2 should be filed w trnent of Heelth and Mental Hygies tant: If item 27 is marked other to Jury or other traumatic event, it. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy N. Sanborn Isabelle Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Heelth at Important: If item 27 is ny Injury or other trat 19636 Olney Mill Rd Brookeville, MD 20833 Zelda McDonald- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Metro Fnrl Svcs 3/22/06 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA 21. 8 gnature of Funeral Serves Licensee 246 N. Washington St Rockville, MD20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 10 YEAR CHRINIC OBSTRUCTIVE PULMOMARY DISCASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Que to (or as a consequence of) Examiner physicien and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) ed by the a detached f 9 Unknown been signed to should be detail 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown ININFFICIONCY 1 KIDNEY 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 凡 △ 24a. Was an Hypothy widisu autopsy performed? 2 No 1 Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ို 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of eath 28b. Time of Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours effector; f To the Funeral Director; f 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MARCH 20, 2006 Fiture Keinz-Muchonz lo D0058542 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Libuse Acinz - MoMeil いだし AVENUE A SIS , WHEATON, MO GEU RGIA 31. Date filed (Month, Day, Year) MAR 2 4 32. Registrar's Signature State 2006 Registrar

SHEITELMAN, CLARR

		Please Type or Print in Black State of Maryland / E)ер:		lealth and i	Mental Hy	giene	006	10985
Physici		1. Decedent's Name (First, Middle, Last) Claire Sheitelman		runoute or	Deam	2. Date of De. Month March 1	ath Da		3. Time of Death 8:30 A. M
/Medic Examin Funeral		4a. Facility Name (If not institution, give street and number) 7104 Adelphi Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birt)	thday)	Hyattsv	If Under 24 Hrs.	8. Date of Bird	4c	County of Dear	th Georges thplace (State or Foreigr
Director		Usual Residence of Decedent	Yrs.	Months Days	Hours Min.	Jan. 2	20,	1921 6	onnecticut
e Marylan ie-f show	ctor	10a. State 10b. County 10c. City, Town Maryland Prince Georges Hyatt							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
ith with th	ai Director	10e. Street and Number 7104 Adelphi Road		10f. Zip Code 2078	32			tize <i>n</i> of What Co	ountry?
172 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examinar must be nutitized at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes X☐ No	an, Mexican, Puer	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, Whit Specify: W	
	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. K	find of Business	/Industry
ygi t, 1	Ве Соп	12 Years 17. Father's Name (First, Middle, Last)		Registraı	18. Mother's Nar	ne (First, Middle,	Maider		01
should the not marked imarked	To	Harry Feinblatt 19a. Informant's Name/Relationship (<i>Type</i> , <i>Print</i>) 19b.	Maili	ing Address (Street		e Zimmen			Zip Code)
l and 2 lealth a om 27 is om trau				urel Hill	Drive,	Randolph Date		ew Jers	
Pages I		1 M Burial 2 Cremation 3 Removal from State	у, сге	matory or other pla emorial (lney, M	
permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even pncs.		21. Signature of Funeral Service Licensee	D 22	2. Name and Addre anzansky 170 Rocky	ss of Facility -Goldberg	Memoria	al C	hapels,	Inc. 1and 20852
/Medical Examiner / Medical Examiner / Medical Examiner as the purial-transit	licai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or ir jury that initiated events resulting in death) Last Due to (or as a consequence of the condition of the cond	of):	Cancer					
death cer e attendir d for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		□Ectopic pregnanc □ Other (specify)	у			23d. Date of de Month	livery Day Year
es that gned be de	by	Part II. Other significant conditions contributing to death but not resulting in	the u	underlying cause giv	ven in Part I.	į	obacco Yes 2		the cause of death?
The ate h page	Completed					24a. Was autop perfo 1 \(\text{Yes} \)		prior to	utopsy findings available completion of cause of 2 \square No
sicien: certific rector,	o Be (25. Was case referred to medical examiner? 1 Yes	tnatio	nt 3□ DOA Ot	26. Place of Dea	ath (Check only o		c Clother (See	-7.1
ing After une		27. Manger of Death 28a. Date of Injury 28b. T		of 28c. Injui		28d. Describe I			Ciry)
al or Attanding s after death. I Diractor: Afte d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, st	reet, factory, office		28f. Location (S City or Tox	Street ar vn, State	nd Number or Ri e)	ural Route Number,
To the Hospital or within 24 hours afte To the Funerel Dirt completely filled in b	ledical (29a. Certifier (Check only one) 1X Certifying Rhysicien: To the best of my knowledge 2 Medical Exeminer: On the basis of examination and manner stated.	, deat	th occurred at the tinvestigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s date an) and manner as d place, and due	s stated. e to the cause(s)
Mithin Comp	M	29b. Signature and tifle of certifier	_		29142			te signed (Mont ch 19, 2	
		30. Name and ourses of person who completed cause of death (Item 23a) (Dr. Charles Boice 10301 Georgia 31. Date filed (Month, Day, Year) 32 Registrar's Signature	A	venue, #	205, Sil	ver Spri	ng,	Marylar	nd 20902
Sta Registr		31. Date filed (Month, Day, Year) MAR 2 3 2006 32. Registrar's Signature	de la	ule)					-

			For 1 = State Registrar	State o	f Marylan		artment of F				iene og. No. 0 U 6	1096	36
¥	Physici	an	1. Decedent's Name (First, Midd John George	le, Last) Shannon		18 18			2.	Date of Deat Month March	Day Yeer	3. Time of	Death p M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town, or	r Location o	of Death	March	4c. County of Death	1:42	Р
	Examini	er	3833 Wendy La		,		Silver Sp	ring			Montgo	mery	
き.	Funeral		5. Social Security Number	6. Sex X □ M 2 □ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under	Min.	Date of Birth (Month, Day,	Year) 9. Birth	place (State of	-
n _S	Director		037-14-1097 Usual Residence of Decedent	№ □M 2□F	80	Yrs.			A	pril 15	, 1925 Rhc	de Isla	and
	land ow		10a. State 10b. County	1	10c. Cit	ty, Town or Lo	ocation					10d. Inside Cit	ty Limits
	Mary B-1 sh	tor	Maryland Mont	gomery	S	ilver	Spring					1 ☐ Yes	2X No
	or 28	Olrec	10e. Street and Number				10f. Zip Code			10	og. Citizen of What Cor	untry?	
	ath w	ral	3833 Wendy L				2090				USA	1	
920	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Thygiene marked other then "natural, or liems 23a or 28a-f show marked other then "natural" or liems 23a or 28a-f show marked other then "natural be notified a	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 ☒ Mai 3 ☐ Widowed 4 ☐ Divorced	ried Armed Fo	2 🗆 No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	Specify:		y Yes or No- ean, etc.)	14. Race - Amer Black, White SpecifyWhit	, etc.	
<u>م</u>	72 ho	Completed		nt's Education est grade completed)			dent's Usual Occup		at of working		16b. Kind of Business/I	ndustry	
2	ithin Te.	nple	Elementary/Secondary (0-12)	College (life.	DO NOT use retired	d) -			G		
2	filed w Hygier Sther ti		17. Father's Name (First, Middle,	(ast)		Commun	nications	-			Governm	ent	
Maryland 21215-0036	ed ta b	To Be	Frank Shannon					Hel	en Sai	unders			
	is 1 and 2 should of Health and Men item 27 is marke other treumatic		19a Informant's Name/Relation: Taimi H. Shan			3833	Wendy La		ilver	Spring	City or Town, State, Z , MD 20906		
Baltimore,	Pages 1 nent of He ant: If iter		20a. Method of Disposition 1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (5)		State	cemetery, cre	osition (Name of matory or other place Vational Cen			h 29,	20c. Location - City or Tarlington,		ia
Balt	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service	Licensee By		F ²	Name and Addre rancis J. 00 Univer	sse Facilit sity	ins Fu Blvd,	neral W, Sil	Home Inc ver Spring	, MD 20	0901
390	Physician /Medical Examiner parial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to Due to	(or as a consec	uence of):	ructive	Puln	nonar	y Dis	Sense	20 ye	Death
.O. Box 68	death certifica e sttending ph id for use as ti	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live I	itcome of pregni birth 2 Feta nant at time of c	Ideath 3	□Ectopic pregnancy	1			23d. Date of deli Month		Year
۵.	S C O	þ	Part II. Other significant condit	ensions contributing to d	leath but not res	sulting in the u	nderlying cause giv	en in Part I.	i.	23e. Did tob	pacco use contribute to	the cause of d	
Secol	ne taw require has been sig ge 2 should b	Completed	Prosta		cer					24a. Was a autops perform	y prior to d	topsy findings ompletion of ca	available ause of
a	sicien: The law certificate has b irector, page 2 s	e Co	25. Was case referred to medical		ncer				(D (1 ☐ Yes 2	No 1 □ Yes	2□ No	
=	s cert	To Be	examiner?	Hospital:	Inpatient 2	FR/Outpatie	nt 3 DOA Oth		ursing Home	5 Reside	nce 6 □Other <i>(Spe</i> o	uhr)	
on of	Attending Phys ir death. ector: After this by the funeral dir		27. Manner of Death 1 ☑Natural 5 ☐ Pendi	28a. Date	of Injury oth, Day Year)	28b. Time o	f 28c. Injur Wor		280		w injury occurred		
Division of Vital Records,	al or Atten after dea I Director d in by the	Certification:	3 Suicide 6 Could 4 Homicide deter	not be 28e, Place	e of Injury - At h ling, etc. (Specia	ome, farm, st fy)	reet, factory, office		28f	Location (St. City or Town	reet and Number or Ru , State)	ral Route Num	ber,
	To the Hospitel or Attending F within 24 hours after death. To the Funarel Director: After completely filled in by the funer.	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	Examiner: On the b	e best of my kno basis of examina oner stated.	owledge, deat ation and/or in	h occurred at the tire to the	me, date an pinion, dea	nd place, and ath occurred	d due to the ca at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s	i)
	To the To the Comp	ž	29b. Signature and title of certific		>	In N	29c. Licens		~		9d. Date signed (Monti		
	8+1)			MD					March 21		06
			30. Name and address of person	who completed cau	se of death (Iter	520 S	Print) GRO	VE RI	1) #200	- ROCK	VILLE, MD	20850)
	Sta Registr		31. Date filed (Month, Day, Year MAR 23	2006	Registrar's Sign	ature	di						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 22 ay 2006 ear **Physician** William Stewart Schneibolk 12:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Potomac 10 Lamp Post Court | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nownth, 8ay, 1946 9. Birthplace (State or Foreign New Jersey 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral X**□ M 2□ F 158-36-1178 59 **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at Potomac Montgomery Maryland 1 ☐ Yes 2 V☐ No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number With ŏ 20854 United States 10 Lamp Post Court Itams 23a filed within 72 hours after death Hygiene. other then "neturel", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0il Trader Mobil, Pira permit. Pagas 1 and 2 should be filled wit Department of Health and Mental Hygiene important: if itam 27 is marked othar tha any injury or othar traumatic event, the longs. 18. Mother's Name (First, Middle, Maiden Sumame)
Sophie Simon 17. Father's Name (First, Middle, Last) Be Max Schneibolk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Lamp Post Court, Potomac, MD 20854 Jacqueline Schneibolk, Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 03/22/06 Alexandria, VA 21. Si nature of Funeral, er rive Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 12 Months Progressive Brain Tumor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the burial-transit or Attending Physician: The law requires that the death certificate ba executed Due to (or as a consequence of): P.O. Box 68760 by Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2∏ No 2√ No 1 Tes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident ector: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by Direc 4 Homicide filled a Funaral 29a. Certifier 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 23308 March 22, 2006 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Victor M. Priego, MD, 6420 Rockledge Drive #4100, Bethesda, MD 32. Pegistrar's Signature 31. Date filed (Month, Day, Year) State MAR 23 2006 Registrar

			1 - For State Registrar	State	of Mai	yland / D	epartme Certifica			and M		gien Reg. N	11116		10988
	Physici		Decedent's Name (First, Middle Will+	on Elmor	e Tho	mas					2. Date of De Month March	Da	ay Yea		3. Time of Death 0848 M
)	/Medic Examin		4a. Facility Name (If not institution			,mas	4b. City	, Town, or	Location of	f Death	Haren		c. County of D		0040
	ZAGIIIII		Harford Men	orial Ho	spita	1		Hav	re de	e Gra	ace		Har	for	:d
	Funeral Director		5. Social Security Number 214-36-9924	6. Sex 1⊠M 2□F	7. Age (In yrs. last birtl	nday) If Under	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da June 3	th V Year	L942 9.1	Count	ace (State or Foreign ny) aryland
	and		Usual Residence of Decedent 10a, State 10b, County		1	Oc. City, Town	or Location							10	d. Inside City Limits
	Maryli f sho	ō	ŕ	ecil		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Per	ryvil	le					1 ŽYes 2 □ No
	r 28e	rec	10e. Street and Number				10f. Z	p Code				10g. C	itizen of What	Count	ry?
	th witt	ai D	100 Greenway,	Apt. No.	222			2	1903				ប.ទ	.A.	
9	permit. Pages t and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mentai Hygiene. Importent: If item 27 is marked other then "neturel; or iteme 23s or 28s-f show ery injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	ied 1 📉 Yes	Forces? s 2 ☐ No Give		13. Was Dece If Yes, sp	cify Cuba	spanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	14. Race - A Black, W Specify:	/hite, e	
Š	ture	ed b	15. Deceden	Year or	Dates: _		Decedent's Usi	al Occup	ation			16h	Cind of Busine		
01717	I within 72 iene. r then "ne Ihe Medic	Completed	(Specify only highes Elementary/Secondary (0.12) Eleven Years	t grade complete	d) (1-4or 5+)		(Give kind of w life. DO NOT Truck	ork done d ise retired	during most)	of worki	ng	н.	Muller	-Th	ym Company Maryland
2	i Hyg other	Be C	17. Father's Name (First, Middle,	Last)						r's Name	(First, Middle	Maide	n Sumame)		
ā	uld by Venta Irked Itic ev	To E	John	Carroll	Thoma	as				Sar	a Rebec	ca	Simper	s	
ō	and lama		19a. Informant's Name/Relations				- 1				I Route Numbe				
≥ 12	and feelth m 27 her tr		Nadine V. Thoma	as (wife	e)				-						and 21903
	Pages I tment of H tent: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	n State	20b. Place of cemetery Asbu	ry Ceme	tery	-	03/2	8/06		ocation - City t Depo		m, State , Maryland
מם	Depar Impor eny in		21. Signature of Funeral Service	. Pate			Perry	Pat ille	terso , Mar	n & ylan		3-0		, P	.A.
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications tha only one cause or	t caused the each line.	se death. Do no		de of dyin	g, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions,	Due t	L/V	consequence of	PAIL	UR	E						
	P # 18	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua t	Utas a d	ATTT.				24	0515	`			
	cate be executed physicien and the burial-transit	xan	that initiated events resulting in death) Last	c	o (or as a	consequence of			/ / /	1//	0 3 / 3			_	
3	sicier s buri	dicai													
2				0.										Ī	- Controlled
.O. DO	Attending Physician: The law requires that the deeth certific r death. ector: After this certificete has been signed by the ettending to the funeral director, page 2 should be detected for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2	pregnancy □ Fetal death ne of death	3 □Ectopic p 5 □ Other (s						23d. Date of Month		y Day Year
62	quires that n signed b uld be dete	Ŕ	Part II. Other significant condition CHRONI	C. KI	DM	SY DI	SEMS	-	en in Part I.			obacco Yes 2			cause of death?
	The law requiresele has been sipage 2 should b	Completed	DIMB	e les	n	IEZL	1705				24a. Was autop perfo		prior	to com	sy findings available pletion of cause of
3	ician: Th	ပိ	25. Was case referred to medical						G. Diago	of Dooth	1 ☐ Yes	2 D N	1 U Y	es 2	: No
	nysicia nis cert direct	0 8	examiner? 1 Yes 2 No	Hospital:	Inpatient	2 ER/Out	patient 3 D	Othe			n <i>(Check only o</i> ne 5 ☐ Resid		6 □Other /S	nacifu)	
5	nding Phi th. r: After thi e Iuneral	atlon: T	27. Manner of Death Natural 5 Pendin 2 Accident investig	28a. Dat (Mo	e of Injury onth, Day Y	28b. Ti		28c. Injury Work	at	2	28d. Describe t			pacity)	
	To the Hospital or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the to	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 286. Plac	ce of Injury ding, etc. (- At home, farr (Specify)	n, street, factor	y, office		2	28f. Location (S City or Tov	Street a. vn, Stat	nd Number or e)	Rural	Route Number,
	o the Hospital or within 24 hours ette to the Funerel Dir completely filled in it	Medical (29a. Certifier (Check only one) 1 Certifyin 2 Medical	g Physician: To a Examiner: On the and ma	e best of r basis of ex nner state	camination and	death occurred for investigation	at the tim	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s date an	and manner d place, and c	as sta	ted. he cause(s)
	To the Comp	×	29b. Signature and title of certifier	Nou	val	enos	8 KH2	C. License	number	9	6	29d. Da	ite signed (Mo	onth, D.	ву, Year) 2006
5	5+1VA		30. Name and address of person	who completed ca	HYE	th (Item 23a) (T	ype, Print)	0 /	25,	N. 14	MIN	57.	BEZ	1771	13,111D2/014
	Sta Registra	te	31. Date filed (Month, Day, Year) MAR 2 8 2006	El agree	Registrar's	Signature	r v								
ЭН	VH 17 Rev 1/20	01	5145 H 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1		-									

			1 - For Registrar	State of M	aryland	•	artment o				gien Reg. No	UUO	10989		
	Physici	an	1. Decedent's Name (First, Middle, Las	,						2. Date of De Month	Da		3. Time of Death		
	/Medic	cal	A P	Carl Gibso		nas	# 65 T-		-(D #-			, 2006	8:01 A. M		
	Examir	ner	4a. Facility Name (If not institution, give			1	4b. City, Tow			_	40	County of Deat			
			5. Social Security Number 6. Se	er George's C		ast birthday)	If Under 1 Ye		onacol		th.		egany hplace (State or Foreign		
	Funeral Director		214-12-3124	M 2□F	83	Yrs.	Months Da			(Month, Da May 26	y, Year,	Co	Maryland		
			Usual Residence of Decedent		0.5					Ividy 20	, 1722				
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits		
	Mar.	tor	Maryland Alle	gany				Lonace	oning				1 ☐ Yes 2 NNo		
	h the	Director	10e. Street and Number				10f. Zip Cod	е			10g. Ci	itizen of What Co	puntry?		
	th wil	a C	15661 Lower Ge	eorge's Creek	Road			2153	39			US	A		
	ems ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. \	Vas Decedent	of Hispanic C Juban, Mexic	rigin? (Sp an, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whit			
36	or it	y Fu	1 Never Married 2 Married	1 XYes 2 □ . If Yes, Give	No		□Yes 201					Specify:			
8	urel	d by	3 X Widowed 4 □ Divorced	Year or Dates:		10.0					121		White		
21215-0036	"net	Completed	15. Decedent's Ed (Specify only highest grad			(Give	lent's Usual Oc kind of work do DO NOT use re	ne durina mo	st of work	ing	160. 8	Kind of Business	industry		
12	withir	Ę	Elementary/Secondary (0-12)	College (1-4or :	5+)	<i></i> 1	001101 03616	Labore	r			Const	ruction		
d 2	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "neturel", or Items 23a or 28a-f show event, the Mcdical Examinar must be notified at		17. Father's Name (First, Middle, Last)							e (First, Middle,	Maider	n Sumame)			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mentai Hygiene. Deportment of Health and Mentai Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23a or 28e-1 show appring the result of the result of the profiled at any injury or other traumatic event, the Medical Examinating the notified at ance.	To Be	Gibso	n Buregard Tl	homas					Blanck	he Ma	ay Timney			
<u></u>	shoul mari	F	19a. Informant's Name/Relationship (7			19b. Mailin	g Address (Str	eet and Num	ber or Rui			or Town, State, 2	Zip Code)		
Ž	od 2 27 is		Barbara Fi	ckes			34	Florida V	Vay, L	onaconing,	Mar	yland, 2153	19		
ē,	s 1 a f Hea item othe		20a. Method of Disposition		1 00	lace of Dispo	sition (Name of	nlace)		Date	20c. L	ocation - City or	Town, State		
ě	Page ent o nt: If ry or		1 ☐ Burial 2 ②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				land Crem			April 01, 2006	(Cumberland	l, Maryland		
Baltimore,	ant. L		21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Fighhorn-McKenzie Funeral Home												
ä	Department of the partment of		E. Mike	محمد		100		8 Fast	Main	St Longeo	ning	MD 21530	me P.A.		
	Physician /Medical		23a. Panf. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each li a	ne. Le Da	sryth	er the mode of	dying, such a	s cardiac	or respiratory ar	rrest,		Approximate Interval Between Onset and Death		
	Examiner			CAD		Control of the Control							> logrs		
	n .=	je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience of):							210000		
	cate be executed bhysician and the burial-transit	Examiner	that initiated events	a. 17/1/	1								2 10 95		
0,	e exe	Ë	resulting in death) Last	Due to (or as	a consequ	ience of):									
8760,	ate b shysic the b	dlcai		d.											
Вох 6	ath certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal	death 3□	Ectopic pregna			190		23d. Date of del Month	ivery Day Year		
P.O.	that the de ned by the a detached f	hys	9 Unknown	9□ Unknown											
	w requires that been signed I should be det	ğ	Part II. Other significant conditions of	ontributing to death b	out not resu	ulting in the u	nderlying cause	given in Par	· I.	23e. Did to	/		the cause of death?		
Records,	icien: The law re certificate has be rector, page 2 sho	Completed	LARYNGEAL (Lancer						24a. Was autop perfo 1 Yes		prior to death?	utopsy findings available completion of cause of		
ita	len: artifica ctor,	Be	25. Was case referred to medical examiner?					26. Pla	e of Deat	th (Check only o	ne)				
>	Physicien: r this certific ral director,	2	examiner? Release	Hospital: 1 Inpatie		ER/Outpatien	t 3□ DOA	Other: 4 🗆 N	lursing Ho	ome 5 Resid	dence	6 □Other (Spe	cify)		
Division of Vital	ending P eath. or: After t		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		iry y Year)	28b. Time of Injury	1	njury at Nork? Yes 2[]No	28d. Describe I	now inju	ary occurred			
Divis	itel or Att rs after de rel Direct led in by t	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, et	ic."(Specify	·)				City or Tov	vn, Stat	e)	ural Route Number,		
	To the Hospitel or Atlanding Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)	ysician: To the best liner: On the basis o and manner st	it examinat	wledge, death ion and/or inv	estigation, in m	y opinion, de	ath occur	red at the time,	date an	d place, and due	o to the cause(s)		
	To 1 To t	Σ	29b. Signature and title of certifier				29c. Lic	ense numbe:	-		29d. Da	ate signed (Mont	h, Day, Year)		
7		6	gaye	Fellegi	e 1	MIZ	1)	ootoc	95		MA	rch 31	,2006		
6	AVA		30. Name and address of person who o	completed cause of o	death (Item	23а) (Туре,	Print)	CI	1 /	1 1	1	0 11	210-		
_			31. Date filed (Month, Day, Year)	32. Registr	ar's Siana	200 (g-lenn	24100	+ (umber	- (AV	x Mel	LUQ		
	Sta Registi			2006 Segistr	aı ə əignat	Mis A	1								

DHMH 17 Rev 1/2001

				• •	aryland / Dep			-	_	10000		
			1 - State Registrar	Otato or ivi		ertificate of			g. No.	10330		
	· ·		Decedent's Name (First, Middle, Last	t)				2. Date of Death Month		3. Time of Death		
	Physici /Medic		Larna U	mbel				3	31 2006	1940 Ly		
4	Examin	er	4a. Fecility Name (If not institution, give		1 11.		or Location of Death	- « n	4c. County of Death			
	Europal	-	5. Social Security Number 6. S	ex 7. Aq	e (In yrs. last birthda)	O Lela	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign		
	Funeral Director		217-80-0804	□M 25€	93 Yrs.	Months Days	Hours Min.	(Month, Day,	/1912 Wes	intry) st Virginia		
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits		
	Manylis fed	ō	MD Garrett		Friend					1 ☐ Yes 2 🔀 No		
	with the 3a or 28a	Funeral Director	10e. Street and Number 13764 Friendsvi	lle Road	<u> </u>	10f. Zip Code 21	531	10	og. Citizen of What Cou USA	intry?		
	ms 2%	nera	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White			
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Exemplation in at the modified.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ∰ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 ☑ No		ricari, etc./		white		
21215-0036	in 72 ho n "natur Autical	Completed by	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of work	ring 1	16b. Kind of Business/li	ndustry		
212	filed withi Hygiene. othar than ent, II.e M	mo	Elementary/Secondary (0-12) 8 th	College (1-4or 5		emaker			Own Home			
pu	be filed ital Hygie od other event, II	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M B ell e Ui				
Maryland	should be ind Mental i marked o umatic eve	ဥ	Owen Christophe 19a. Informant's Name/Relationship (10b Mai	ling Address (Street			City or Town, State, Zi	in Code)		
Mai	od 2 sho Ith and 27 is m		Doris G. Rodeheav			•	Rd., McHe		21541	p C00e)		
ē,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition		20b. Place of Disa			-	20c. Location - City or T	own, State		
imo	mit. Pages bartment of ortant; If It injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Specify			ade Cem.	Apr 3,	2006 F	riendsvill	e, MD		
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service Licer	lacono) N		eral Home		PO Box 275			
			23a. Part1. Enter the disease, or com shock, or healt failure. List only	ofications that caused one cause on each li	the death. Do not e	nter the mode of dyi	ing, such as cardiac	or respiratory arre	y 1'10 2100 st,	interval between		
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Preus	monde					3-5 days		
Н	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):							
	ed sit	Juner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):							
oʻ	a be executed sician and s burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):							
3760,	ate be hysicia the bur	Ical		. d								
x 68	sertifica ding plasses as t	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy		207		22d Date of della			
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	ey		23d. Date of deliver Month	/ery Day Year		
ls, P.	ires that signed b	by Pt	Part II. Other significant conditions of	=	ut not resulting in the	underlying cause gr	1 1		acco use contribute to s 2 □ No 3 □ Pro			
Sor	w requir been si should	etec	Longestice of	+12 5ter	-	10.00		24a. Was an		opsy findings available		
of Vital Records,	The law cate has page 2 s	ошо	anese, Hor	7,0	75.15			autopsy perform	prior to co	ompletion of cause of 2 □ No		
ital	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?					h (Check only one	9)			
of V	Physician: this certificatal director, I	P	1 □ Yes	Hospital:					nce 6 □Other (Spec	ify)		
	ath. rr: After ne funer	ation	7. Manner of Death 12									
Division	i or Atte after de Diracto	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, s c. (Sp cify)	street, factory, office		28f. Location (Str City or Town,	eet and Number or Rui , State)	ral Route Number,		
-	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certific: completely filled in by the funeral director, I	edicai C	29a. Certifier (Check only one) Certifying Ph	ysician: To the best niner: On the basis o and manner st	f examination and/or	ath occurred at the ti investigation, in my	ime, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)		
	Fo the within Fo the Fo the comple	Me	29b. Signature and title of sertifier	/2 /			se number		d. Date signed (Month	*		
	- >- 0				1	DØ	Ø6157A	8	3/31/20	106		
	2	70	30. Name and address of person who	τ ().	eath (Item 23a) (Type	a, Print)	317 B	Mien A	3/31/20 he onklo	12130		
	Sta Registi		31. Date filed (Month, Pay Year)	32. Registr	ar's Signature	Areadh s						

		1 - State Registrar			-	artment o	of Death			Reg. No.	J U O	10331
Physicia	an	Decedent's Name (First, Middle, La	,						2. Date of Di Month	eath Day	Year	3. Time of Death
/Medic	al		oh Anto		uez				MARCH	24		06:15P ^
Examin	er	4a. Facility Name (If not institution, give					vn, or Location	of Death			County of Dea	ith
ıneral		VA MARYLAND HEALT 5. Social Security Number 6.5		7. Age (In yrs.	last birthday)		POINT ear If Unde	r 24 Hrs.	8. Date of Bi		CECIL 9. Bir	thplace (State or Foreig
erai		*	M 2□F	85	Yrs.	Months D	ays Hours	Min.	(Month, D Jan.]	av. Year)	C	ountry) lerto Rico
		Usual Residence of Decedent										
0005	_	10a. State 10b. County		10c. Ci	ity, Town or Lo							10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Director	Maryland Cec	11			Perry						
	Ö	10e. Street and Number 350 Broad Street				10f. Zip Co		903		10g. Citiz	en of What C	
	Funeral	11. Marital Status	12. Was Dec	edent Ever in L	J.S. 13. V	Vas Decedent			ecify Yes or N	0- 1-	U.S.A	
	Fun	1 Never Married 2 Married	Armed F	orces?					ecify Yes or N Rican, etc.)		Black, Whi	
	by	3 ☐ Widowed 4 🎖 Divorced	If Yes, Gi Year or D	2□No ve Dates: 1946	-47	I⊠Yes 2□	No Specify	" Pue	rto Ri	can 5	Specify:	White
	Completed	15. Decedent's E (Specify only highest gr			16a. Deced	lent's Usual O	ccupation	st of work	ina	16b. Kin	d of Business	/Industry
	nple	Elementary/Secondary (0-12)	College (one during mo etired)		<i>y</i>			
	S	Twelve Years	1		S	ecurity	y Guard			1	unkno	own
	Be	17. Father's Name (First, Middle, Last		_			18. Motr		e (First, Middle			
	²	19a. Informant's Name/Relationship (Vazquez	•	10h Mailie	a Address (Ct			afaela a/Route Numb			7- Codel
1		Maj. Raymond Vaz	•	son)	1	-			apolei,	-		26707
		20a. Method of Disposition	quez (Place of Dispo		and the same of the same of		Date		ation - City or	
		1 ☐ Burial 2 🛣 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		State	cemetery, cren A. Ferris			03/2	6/06			Pennsylvania
OI (21. Signature of Funeral Service Lice		10.2	22	. Name and A	ddress of Facil	lity				
a		Mhonros hit	MAREN	S. W.	. L∈	e A. P	atterso	on &	Son Fun	neral 903-0		P.A.
		23a. Part1. Enter the disease, or com	plications that	caused the dear							700	Approximate
arı		shock, or heart failure. List only Immediate Cause (Final			IODD 14T	mii Meem	a CCII a C T C	,				Interval Between Onset and Death
al		disease or condition resulting in death)		CATE CAL (or as a consec		TH META	ASTASIS	<u> </u>				UNKNOWN
er		Process Market States and Million	b									
	Iner	Cause (Disease or injury		(or as a consec	quence of):							
	Examine	that initiated events resulting in death) Last	C. Due to	(or as a consec	augaga of):							
			Due to	(Or as a consec	quence or):							
	dical		_ d								-	
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregn	ancy					25	3d. Date of de	liven
	ciar	in the past 12 months?		oirth 2 ☐ Feta nant at time of c		Ectopic pregn Other (specifi		_			Month	Day Year
	hysi	9 Unknown	9□ Unkn	own								
	y P	Part II. Other significant conditions	ontributing to d	eath but not res	sulting in the ur	nderlying cause	given in Part	I.	23e. Did	tobacco us	e contribute t	the cause of death?
1	edt	RHEUMATOID ARTHRI	TIS						1 🗆	Yes 2	No 3∏P	robably 4X Unknown
	Completed by								24a. Was		24b. Were at	utopsy findings available completion of cause of
Ì	E O								auto perfe	ormed?	death?	2 No
- 1	Bec	25. Was case referred to medical examiner?	= = =				26. Plac	e of Death	Check only			
- 1	T0.	1 ☐ Yes 2 🏡 No	Hospital: 1 🗆	Inpatient 2	ER/Outpatien	3 □ DOA	Other: 4 2 N	ursing Hor	me 5□Res	idence 6	☐Other (Spe	cify)
1	:uo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a, Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe			
	catl	2 Accident investigation 3 Suicide 6 Could not be	1.			М	1 ☐ Yes 2 ☐	_				
	Certification:	4 Homicide determined	286, Place	of Injury - At h ing, etc. <i>(Speci</i>	ome, farm, stre fy)	eet, factory, off	ice	1	28f. Location (City or To	'Street and wn, State)	Number or R	ural Route Number,
	Ce	200 Continu	velelen. T. de	- h 1 - (1				+				
	edical	29a. Certifier (Check only one) 2 Medical Exer	niner: On the b	e best of my kno asis of examina ner stated.	ation and/or inv	occurred at the estigation, in r	ne time, date ai my opinion, dea	nd place, a ath occurre	and due to the ed at the time,	date and p	ind manner a: place, and due	s stated. e to the cause(s)
1	Med	29b. Signature and title of certifier	A III III III	ioi stated.		29c. Lic	ense number			29d. Date	signed (Mont	h, Day, Year)
		10/	Lent								4-01	_
		180	1 4 1/2			1 1)10	402			many : when	(
		30. Name and address of person who	completed caus	se of death (Iter	n 23a) (Type		2502					
completely filled in		30. Name and address of person who	#	se of death (Iter		Print)		VSTEN	M. DEDD			21902

James Wieland Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,perME,g856,6/7/06 III State of Maryland / Department of Health and Mental Hygiene 06-2202 AKG Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 Physician James Hunter March 30, Wieland 1:17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery General Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 12 Months Hours 1**₹** M 2 ☐ F 220-73-7406 Yrs Director 3 18, 2005 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. fnside City Limits Item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at Maryland | Montgomery Silver Spring 1 ☐ Yes 2 X No Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 1923 Hickory Hill Lane 20906 USA filed within 72 hours after death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □Yes 2♣ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 Is marked ot William Hunter Wieland Moira Anne Geddes ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code William Hunter Wieland/ Father 1923 Hickory Hill Lane, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 4, 20c. Location - City or Town, State ō 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or ance. Gate of Heaven Cemetery 2006 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sudden infant death syndrome (SIDS) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (ur as a consequence of, Examiner anding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2□ No 24a. Was an autopsy performed? certificate 2□No Yes After this certification Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 npatient 2 ER/Outpatient 3 DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To XXYes 2 □ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending I Director: A d in by the fr investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) illed in by 4 Homicide

within 24 hours after To the Funeral Dire

State Registra

Medicai

(Check only one)

29b. Signature and title of certifier

Humela Southall, MD 31. Date filed (Month Day, Year) 32. Registrar's Signature 04 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the fiest of my knowledge, death uccurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

March 31, 2006

29d. Date signed (Month, Day, Year)

111 Penn Street, Baltimore, Maryland

			1 - For State Registrar	State o	f Maryla				lealth an <i>Death</i>	d Me		giene Reg. No	Sept. Sect. 1874		1993		
			Decedent's Name (First, Middle, L.	ast)						2	Date of De	aath			3. Time of Death		
	Physici		Thoodore Weigher	0.020						Ι,	Month	Da	,	ar	1 (OF M		
>	/Medic		Theodore Weinber 4a. Facility Name (If not institution, gi		mber)		4b. City.	Town o	r Location of D		March		2006 County of D	eath	1:40P "		
	Examir	er						_	_	out.			•				
			8100 Connecticut 5. Social Security Number 6.	Ave, #1		. last birthday)		vy C		Hrs o	. Date of Bir		Mont	gom	ery		
	Funeral			1 XM 2 ☐ F		. V.	Months			⁄lin.	(Month, Da	ay, Year)			ace (State or Foreign ry)		
	Director		Usual Residence of Decedent		9	4 115.				S	ept 7,	, 19	11	New	York		
	and w		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10	d. Inside City Limits		
	eho	5				,,									1 X Yes 2 □ No		
	8a-f	ctc	Maryland Montgo	mery	Ch	evy Cha											
	ith th	i.	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of Wha	Count	ry?		
	15 w	le.	8100 Connecticut	Ave, $#1$	L506		2	0815				1	USA				
	dea	by Funeral Director	11. Marital Status		edent Ever in t	J.S. 13.	Was Dece	dent of H	ispanic Origin' an, Mexican, Pi	(Specif	y Yes or No)-	14. Race - A Black, V				
9	or it	T.	1 ☐ Never Married 2 ☑ Married	1 XYes If Yes, Giv	2□No 19	41-	1 ☐ Yes		Specify:		ALT, 010.7			*11110, C	10,		
8	ours	b	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates: 19	44	103	212110	зреспу.				Specify:	Wh	ite		
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Itema 23e or 28e-f ehow the Medical Exartinat rusat by routified at	Completed	15. Decedent's E (Specify only highest g	ducation		16a. Dece	dent's Usu	al Occup	ation during most of	working		16b. K	and of Busine	ss/Ind	ustry		
2	nie e	pje	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	DO NOT u	se retired	d)	working							
2	A STATE OF THE STA	υo	,	-	5+	Juc	lae						Law				
0	oth oth	Bec	17. Father's Name (First, Middle, Las				8-		18. Mother's	Name (irst, Middle	, Maider					
<u>a</u>	ld be enta ked ic e	To B	Albert Weinberge	~					Henrie	.++.	Ctown						
Maryland	Shou od M mar	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street	and Number of				or Town. Star	e. Zip	Code)		
Z	d 2 th a trail	ll i	01.1.1	/*** 6		233035									1.75-25-5		
a,	Heal Heal em 2		Shirley Weinberg 20a. Method of Disposition	er/wife_	20b.	Place of Dispo cemetery, crer	sition (Nar	ecti me of	CUE AVE	Date	15Ub	20c. L	ocation - City	or Toy	MD 20815		
ŏ	Se = 10		1 ☑ Burial 2 ☐ Cremation 3		State				:e)			200. 2	30411011 0119	0. 10.	vii, otato		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or itema 23e or 28e-f show may njury or other traumatic event, the Medical Exantinatinatic an once.		4 ☐ Donation 5 ☐ Other (Spec	•	Ju	dean Me					4, 200		01ney	-			
ā	epar epar npor ny in		21. Signature of Funeral Service Lice	22 Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904													
ш	₫ O E @ O		May	Wow	موه	11	1800	New	Hampshi	re A	Ave, S	Silve	er Spr	ing	, MD 20904		
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that c	aused the dea	ith. Do not ent	er the mod	te of dyin	g, such as care	diac or r	espiratory a	rrest,			Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition resulting in death) Pnuemonia Due to (or as a consequence of):												Onset and Death 24 hrs		
4	/Medical														Z4 IIIS		
	Examiner		Duo to (of as a consequence of).														
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):								_			
	nsit	nin.	if any, leading to immediate														
	and and al-tra	хаг	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):								-			
9	be e icien buria	E E		,		, .											
68760,	ificate be executed g physicien and as the burial-transit	edical Examiner		_ d								_		+			
			IF FEMALE:						-	-							
Вох	death cert e attendin	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out 1□Live b	come of pregn irth 2 ☐ Fet		Ectopic pr	гедпапсу					23d. Date of		*		
	od fo	SICI	1 ☐ Yes 2 ☐ No	4∏Pregn 9∏Unkno	ant at time of		Other (sp						Month	ı	Day Year		
P.0	that the de led by the a detached t	Physician/M	9 Unknown														
	The law requires that the ate hes been signed by the bage 2 should be detache		Part II. Other significant conditions	contributing to de	ath but not re	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco	use contribut	e to the	cause of death?		
5	quire nn sij uld b	Ba	Arteriosclerotic	cardiov	ascula	r disea	ıse				1 🗆 1	Yes 2	□No 3□	Proba	bly 4 ⊠Unknown		
၀	w requii been s should	Completed by	Parkinson's dise	200							24a. Was	an	24b. Were	auton	sy findings available		
Re	he fav	Ē	Tarkingon & disc	430						-	autop		prior	to com	pletion of cause of		
a											1 Yes	2 🔀 No	10	es 2	2 🗆 No		
of Vital Records,	Physicien: The this certificate he ral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Oth	26. Place of I								
5	Phys this ral dii	၉	1 ☐ Yes 2 ☐ No	1 📗		ER/Outpatien			4 Nursin				6 Other (S	pecity)			
	ding lh. After funer	0	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Mont	h, Day Year)	28b. Time of Injury		8c. Injury Work		280	I. Describe !	now inju	ry occurred				
<u>S</u>	Attending in death. Ctor: After by the fune	cati	2 Accident investigation	1			М	10	Yes 2□No								
Division	or Attencater death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	288. Place	of Injury - At h	nome, farm, str	eet, factory	y, office		28f	Location (S City or Tox	Street an	d Number of	Rural	Route Number,		
	tal or	Cer											,				
	Hospital (24 hours a Funeral Distely filled i	edicai	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the	best of my kn	owledge, death	occurred	at the tim	e, date and pl	ace, and	due to the	cause(s	and manne	as sta	ted.		
	n 24 n 24 ne Fi	edic	(Check only 2 Medical Exa	and manr	ner stated.	ation and/or inv	vestigation.	, in my of	oinion, death o	ccurred	at the time,	date and	place, and	due to	the cause(s)		
	To the Hos within 24 h To the Fur completely	Ž	29b. Signature and little of certifier	1 1			290	. License	number			29d. Da	te signed (M	onth, D	lay, Year)		
	1		1/4/117	Alle	de			1	013818			Ms	arch 2	3. '	2006		
	0	1	30. Name and address of person who	completed caus	e of death (Ite	m 23a) (Tyne	Print)		213010			1.15	21 011 2	, ,			
								t 0	#720 0	'h	. Ch -		ന വര	1 =			
	Sta	to.	Gary P. Fisher, 31. Date filed (Month, Day, Year)		egistrar's Sign	nsin Av	e, 5	LE.	17/30, C	mevy	onas	e, I	שע בעס	TJ			
	Registr			006	aus S	ature											

			1 - For State Registrar	State of Marylar		artment of F rtificate of		F	leg. No.	6	099	94
١	Physic	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month MARCH		Year_	3. Time of [
	/Medi	cal	ETHEL	C. WAINWR	LGHT						1:20) PM
	Examir	ner	4a. Facility Name (If not institution, give s 531 Randolph		6 7\	4b. City, Town, o	r Location of De		4c. County	of Death TGOM	אכובו	
	Funeval		5. Social Security Number 6. Sex			If Under 1 Year		_				· Cornina
	Funeral Director			M 25€F 7		Months Days	Hours Mi		,1929	Mar	ace (State or ry) yland	3
	e Marylan ta-f show	ctor	10a. State 10b. County MD Montgo		ty, Town or Lo	silver :	Spring			10	d. Inside City	•
	23a or 28	al Director	10e. Street and Number 531 Randolg	h Road, #2	26A	10f. Zip Code	0904		l0g. Citizen of W	hat Count	ry?	
920	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show ta Madleal Exemiter meat te motified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	I2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of F f Yes, specify Cuba 1 ☐ Yes 🏋 No	lispanic Origin? an, Mexican, Pud Specify:	(Specify Yes or No- erto Rican, etc.)		- America k, White, e Bla	tc.	
215-0	hin 72 hou e. en "natura Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	rorking	16b. Kind of Bus	siness/Indu	ustry	
7	filed wit Hygiene other the	Соп	12th			Domest:	ic		Но	me		
n n	tal Hy	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Sumame	9)		
Ş	d Mental	2	Samuel E. Nor					ttie Dor				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28a-f show simply injury or other traumatic event, the Medical Examination must be multiled at ance.	,	19a. Informant's Name/Relationship (Tyn Cynthia G. Link 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service License	(Daughter) 360 Place of Dispo semetery, cren) Nati		ington m 3/2	Rd., Be Date 5/06 SNOWDEN	ltsvil 20c.Location (Laure)	le, City or Tow	MD 20 m,State aryla:	nd
m	8818	-	Crear &	Lugar	2	46 N. Wa	ashingt	on St.,				1 . 2 2
8760,	Physician by Medical Examiners of the private of th	dical Examiner	shock, or heart failurs. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Tary, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of): uer.ce of):	yopath	•				Interval Betwo	een eath
.O. Box 6	I the death certif by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	Bc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery	y Day Ye	9 a r
rds, P	quires that n signed t	by	Part II. Other significant conditions cond						pacco use contril			
Vital Records,	sician: The law require certificate has been si irector, page 2 should b	e Completed		tesi- Ashe	n T)sear		24a. Was a autops perforr 1 □ Yes 2	ned? de	ere autops ior to comp ath? Yes 2	sy findings av pletion of cau	/ailable use ol
5	Physician: this certifica al director, j	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	ospital:	ER/Outpatien	3 DOA Oth		eath Check only on				_
on of	nding Phy th. : After this s funeral c		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	4 🗀 ivursing	Home SE Reside				
UIVISION	ital or Attending Physician: T is after death. al Director: After this certificat led in by the funeral director, pg	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, larm, stre	eet, factory, office		28l. Location (St City or Town	reet and Number o, State)	or Rural F	Route Numbe	er,
	To the Hospital or At fwithin 24 hours after of To the Funeral Direct completely filled in by	ledicai	one)	ician: To the best of my kno er: On the basis of examinal and manner stated.	wledge, death tion and/or inv	occurred at the timestigation, in my op	ne, date and place pinion, death occ	ce, and due to the ca curred at the time, d	ause(s) and man ate and place, ar	ner as stat	ted. he cause(s)	
	5 Table 1	Σ	29b. Signature and title of certifier	1		29c. License			9d. Date signed		ay, Year)	
	3		30. Name and address of person who con	npleted cause of death (Item	23a) (Type, F		456		322-	-04		
			Dpinder Singh,	M.D. 1430) Gall	lant For	K In.,	Bowie,	MD 207	10		
¥	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 2 4 2006	32. Registrar's Signa	ture							

		101	partment of Health and Me ertificate of Death		ene () () () ()	10995
	13	Decedent's Name (First, Middle, Last)	2	2. Date of Death Month	Day Year	3. Time of Death
Physici /Medio		JAMES HENRY WELCH	м.	ARCH	25 2006	12:49P M
Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
Formul	- 1	LAURELWOOD CARE CENTER 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	ELKTON If Under 1 Year If Under 24 Hrs. 8	Date of Birth	CECIL 9. Birth	place (State or Foreign
Funeral Director		420-20-5549 1\\\X\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Months Days Hours Min.	(Month, Day, Y	(ear) Cou	KENTUCKY
pue		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits
Marylan f show	JO.	DELAWARE NEW CASTLE NEWA				1 Tyes 2 No
ith the M or 28e-1	Director	10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Cor	intry?
23e o		1639 OLD BALTIMORE PIKE	19702	UN	NITED STAT	ES
er dea	Funeral	Armed Forces?	. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
urs aft	by F	1 □ Never Married 2 ☆ Married 1 □ Yes 2 ☆ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: WH	ITE
be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or iteme 23e or 28e-f show event, the Madical Examirer must be mailified at	ted		edent's Usual Occupation e kind of work done during most of working		6b. Kind of Business/l	ndustry
ithin 700.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
Hygien Therti		10 CHEM 17. Father's Name (First, Middle, Last)	ICAL OPERATOR 18. Mother's Name (First Middle Ma	CHEMICAL.	
id be filec ental Hyg ked othe ic event,	To Be	JAMES WELCH	STELLA T		ardon outrialno,	
2 should be filed within and Mental Hygiene.	۲	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural I		City or Town, State, Z	p Code)
Cy man y man y man y man a stand 2 should thealth and Men Item 27 is marke other traumatic			OLD BALTIMORE PIKE			
permit. Pages 1 and 2 Department of Health s Important; if Item 27 is any injury or other tra		20a. Method of Disposition 20b. Place of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State CRACET.A	ematory or other place)	te 20	oc. Location - City or 1	own, State
it. Pa urtmen ortant; njury	1				NEW CASTI	
permit. Departr Importa			22. Name and Address of Facility R.T. 22 WEST MAIN STREET			
		23a. Part I. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	talure			Onset and Death
ted nslt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
ate be executed hysician and the burial-transit	Exar	that initiated events c. resulting in death) Last Due to (** as a consequence of):				
by se	dical	o Sprene Acre	rinery DEMENTA			
The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as the	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delin	very Day Year
es that the gned by be detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to	
requir een si				1 Tes	2√No 3 Pro	bably 4 Unknown
ar necon: The law content of the	Completed				prior to c death? No 1 Yes	opsy findings available ompletion of cause of
ysicle s certil directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (ce 6 □Other (Spec	ifv)
ng Phy ter thi	n: T	27. Manne of Death 12. Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year)		d. Describe how		-97
tendir eath. Ior: Al	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
s after d	Certification:	4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide	street, factory, office 28	f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
To the Hospital or Attending Physiclen: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) 1. Certifying Physicien: To the best of my knowledge, deal control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	d due to the cau I at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
To the To the Comp	Σ	29b. Signature and title of officier	29c. License number	290	d. Date signed (Month	, Day, Year)
		* /# /vec	D54073	141	Ach 27.	red
5			explants Com N	EN CAD	IF, DF /	8720
Sta Regist		31, Date filed (Month, Day, Year) MAR 2 8 2006 Mark 2 8 2006			-	

Stanley Victor Whyte Amend item 28a per me 854 4-14-06 vt
Please Type or Print in Black Indelibie Ink. Ensure All Copies Are Legible.
d item# 23a, 27, 28a-f, perMF, (854, 4/12/06 TT)
State of Maryland / Department of Health and Mental Hygiene 06-02206 d1Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 30, Day 2006 Year **Physician** STANLEY VICTOR WHYTE 2:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u>Old Mill Branch Creek</u> Berlin
If Under 1 Year Worcester If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 24, 1947 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours 58 034 52 1962 Director England Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Maryland Worcester 1 Yes 2 No Directo Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 8301 Newark Road Iteme 23a 21841 U.S.A. Funerai deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status s 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene.
Item 27 is marked other than "natural", or ite 10. 1 ☐ Never Married 27 Married 1 ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Edward Whyte other traumatic Adeline Boynton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8301 Newark Road Newark, MD <u>Camille J. Whyte</u> 21841 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
eny injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. April 2,2006 Frankford, DE 22. Name and Address of Facility 21. Signature 108 William St. Dutale The Burbage Funeral Home Berlin, MD 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician Drowning complicated by hypothermia resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examine physicien and the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 5 Other (specify) 1 Yes 2 No been signed by the s should be detached 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 XYes 2□ No 24a. Was an autopsy performed? certificate 1 Yes 2 □ No ector. Be 25. Was case referred to medical examiner? 26. Place of Death Check on V one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 POther (Specify) SCENE ٩ 1X Yes 2 No ₽ 28a. Date 34-130-06 (Monn, Day Year) this 28d. Describe how injury occurred Subject drowned 27. Manner of Death 28c. Injury at Work? Medical Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 💢 No and was exposed temperatures Director: / 2/X Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Old Mill Branch Creek Berlin, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide determined hours after within 24 hours aft To the Funeral DI completely filled in found in creek Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie

State Registrar 31. Date filed (Month, Day, Year) APR 04

Southall, MD

one)

29b. Signature and title of certifier

tamela

B. Southall, mo 111 Penn Street Baltimore, Maryland 21201 Pegistrar's Signature

completed cause of death (Item 23a) (Type, Print)

To the

29c. License number

OCME

29d. Date signed (Month, Day, Year)

March 31, 2006

State of Maryland / Department of Health and Mental Hygiene () () () Amend Items 3,8,20 per FH/Dr 6855,05/11/06dhb Reg. No. 111997 For State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11:27 Asa Edward Wilhelm 2006 April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8590 Avilton-Lonaconing Rd. Lonaconing Garrett | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1011 | Months | Days | Hours | Min. | April 1 | 1, 2006 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 95 Director 217-10-1226 Maryland Usual Residence of Decedent 10a. State ahow 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23a or 28e-f ahov treumatic event, Ita Medical Exama act mast by rivilified at 1 ☐ Yes 2 X No Director Garrett Lonaconing 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8590 Avilton-Lonaconing Rd. 21539 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: þ 3 ℃ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. Iem 27 Is marked other than Garrett Co. Roads Dept Road Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Olin Wilhelm 2 Ada Elizabeth Garlitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importsnt: If item 27 Is rr any injury or other treum Allen E. Wilhelm/Son 7057 Avilton-Lonaconing Rd., Lonaconing, MD 21539 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Blocher Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Frostburg, Maryland 21. Signature of Funeral Service Literases 22. Name and Address of Facility Newman Funeral Homes, P.A. auma P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arterio sdevoti c cormary vasalardisano Immediate Cause (Final disease or condition **Physician** year S resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed that initiated events resulting in death) Last physician at s the burial-t Due to (or as a consequence of): Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown ģ signed by the period Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page certificate 1 Yes 2 No Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To o this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Natural 2 Accident Division 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide I in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 122015 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 P. Daniel Miller, D.O., 69 Wolf Acres Rd., Oakland, Maryland 31. Date filed (Month, Day, Year)
APR - 4 2006 32. Registrar's Signature State Registrar

				y pe or Prin State of Ma	ryland / D	epartm		lealth and M	Mental Hy	17%	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0998
	Physicia		1. Decedent's Name (First, Middle, Last) Russell Stauff	er Wa	chter				2. Date of Dea Month March	Day 20	2006	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stickline Hospice Hous 5. Social Security Number 6. Sex	е	(In yrs. last birt			Airy If Under 24 Hrs.	8 Date of Birt	th.	Frede	
	Funeral Director			M 2□F	84	rs. Mor	ths Days	Hours Min.	Aug 23	, 192	21 Ma	aryland
	Ba-fahow	Director	Maryland Freder	rick	10c. City, Town	Key	mar			10g Citi	zen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🏲 No
	sath with the 23s or 2	eral Dire	12153 Woodsboro	Pike	Ever in LLS		f. Zip Code	21757			U.S.	٩.
0020	urs after de al', or Item Ever oer	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 1 1 If Yes, Give Year or Dates:			specify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:	o Rican, etc.)		Black, White	
0-6171	be filed within 72 hours atter death with the Maryland tial Hygiene. A period of other than "natural", or items 23a or 28a-f ahow avent, the Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation co <i>mpleted)</i> Coltege (1-4or 5		(Give kind o life. DO N	Usual Occup of work done OT use retired	ation during most of wor d)	king	16b. Ki	dairy	industry
שמ	be filed ital Hygi id other avant,	To Be Co	11 17. Father's Name (First, Middle, Last) Steiner Wachter				drille!	18. Mother's Nan	ne (First, Middle,		Sumame)	
, mary	s 1 and 2 should I Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type Marilyn Wachter/ w		12	153 W	oodsbo	and Number or Ru ro Pike	Keyma	r, M	ID 21757	
Saltimore	permit. Pages 1 and Department of He Important: If item any injury or oth once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		Haugh	s Cem	or other place etery ne and Addre	3/2	4/2006 artzler Woodsbo	Lad Fune		, MD
*	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each lir	10.	ot enter the	mode of dyir	in St. 19, such as cardiac ROVASC DISEAS	or respiratory a	rrest,		Approximate Interval Between Onset and Death
10 10	be executed ician and purial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of	of):	AR	DISEAS	E			YEARS
cox	he death certificate to the attending physic ched for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		pic pregnancy or (specify) _	1			23d. Date of del Month	ivery Day Year
rds, F.	w requires that the de been signed by the a should be detached t	þ	Part II. Dther significant conditions con	tributing to death b	ut not resulting in	the underly	ring cause giv	ren in Part I.				the cause of death?
Hec	The law ate has b page 2 s	Completed							24a. Was auto perio 1 🗆 Yes		prior to death?	itopsy findings available completion of cause of 2 No
Division of Vital	ling Physician: After this certific tuneral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Natural 5 Pending investigation	DOA Oth	er: 4 🗆 Nursing H	ath (Check only of lome 5 Resi 28d. Describe	dence how inju	ry occurred	city) HOSPKE			
DIVIS	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	c. (Specify)				City or To	wn, State	a)	ural Route Number,
Ì	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier Check only one) 29b. Signature and title of certifier		examination an			pinion, death occu		date and		to the cause(s)
	WJL,		30. Name and address of person who co	mpleted cause of o	eath (Item 23a)	(Type, Print)) or	0/43/7	inthicum	3,	120/2	2006
	100		ONE KIPES ?	RIVE,	TANE	YTO	W/S	iam R. L MARY	CAPD	21	1787	

Registrar

DHMH 17 Rev 1/2001

MAR 2 3 2006 Marks Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death March **Physician** 2006 0340 Jacqueline L. Zepp /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Iorien of Taneytown

5. Social Security Number 6. Sex Taneytown Carroll 8. Date of Birth (Month, Dev. Year) OCTODEL 5 1944 If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🖾 F 61 Yrs Director 219-42-9489 Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits parmit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Haalth and Mantal Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 1 □xYes 2 □ No Funeral Director MD Carroll Taneytown 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 100 Antrim Blvd. 21787 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2√2No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2√2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LPN Respiratory Therapy 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Rosenstein Calvin E. Zepp 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 North Main Street Union Bridge, MD 21791 James Rowe/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kriders Church Cemetery 3/29/2006 Westminster, MD 21. Signature of Furieral Service Licensee 22. Name and Address of Fecility Pritts Funeral Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Por 1. Enter the diameter or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, mock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of): Examiner attending physician and for use as the bunal-transit To the Hospital or Attanding Physician: The law requires that the daath carificate ba axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? has 1 LL Yes 2 € No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: ို Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After t 1 Laturel 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Diractor: A completely filled in by tha f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted. edicai (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 30. Name

Westnister mo 21157

eddress of person who completed cause of de

			For State Registrar	State of Ma	ryland		ırtment <i>tificate</i>			and M		giene Reg. No.	A particular of the second	11000
	Physici /Medic		1. Decedent's Name (First, Middle, La: Paul Richard Arn	•							2. Date of Dea Month April	ath Pay	2005	3. Time of Death 6:30 a M
,36	Examin		4a. Facility Name (If not institution, give Carroll Lutheran					stmi	nster	7		4c.	County of Deat	_
	Funeral Director		702-10-7022	ex 7. Age ☐ M 2☐ F	(In yrs. las	t birthday) Yrs.	If Under 1 Months	Year Days	Hours	Min.	8. Date of Birt (Month, Da Aug. 5	y. 184	9. Birti 7 Ma	nplace (State or Foreign unity) ryland
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll		10c. City, 7	Town or Lo	cation	er						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 3a or 28a	Funeral Director	10e. Street and Number 1311 Old Westmins	ter Pike			10f. Zip (Code 211	57			10g. Citi	zen of What Co	•
36	4 within 72 hours after death with the Maryland jiene. r then "natural", or Items 23a or 28a-f show Ite Medical Evantier must be neitlied at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			Vas Decede I Yes, specif		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, White Specify:	
21215-0036	within ene. than "	Completed	15. Decedent's Et (Specify only highest grade) Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+		16a. Deced (Give life. L	lent's Usual kind of work DO NOT use	Occupa done d retired,	tion u <i>ring</i> mos	t of work	ing		nd of Business/	
Maryland 2	be filled staf Hyg ed othe event,	To Be C	17. Father's Name (First, Middle, Last, John R. Arnold								(First, Middle, larie Ri			
, Mar	nd 2 shallth and 27 is m	•	19a, Informant's Name/Relationship (Helen Holland – da							r Pi	ke, Wes	stmi		Md. 21157
Baltimore,	0 0		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		cem	netery, cren	sition (Name natory or oth Park	her place			1,2006		ocation - City or	
Balti	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licer	see S ₁		3	Nama and 196 Ch	Address 1217M	nders il Dr	n Ch Ma	apel P.	A.	Md. 2110	02
	/Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a	esti	nce of):	bstr	en	g, such as	fo	ulro	re		Approximate Interval Between Onset and Death
,0928	death certificate be executed e attending physician and ed for use as the burial-transit		resulting in death) Last	Due to (or as a	conseque	nce of):								
O. Box 6	at the death certifica by the attending ph tached for use as th	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the second of	2 ☐ Fetal de	eath 3	Ectopic pre Other <i>(spe</i>						23d. Date of del Month	ivery Day Year
Д.	The law requires that the steep seem signed by the bage 2 should be detache	by	Part II. Other significant conditions of	contributing to death bu	t not resulti	ing in the u	nderlying ca	use give	n in Part I		23e. Did t		use contribute to □ No 3 □ Pr	o the cause of death?
Vital Records,		Completed									24a. Was autor perfo 1 Yes		prior to	utopsy findings available completion of cause of
of	Attanding Physician: The or death. actor: After this certificate by the funeral director, pag	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation	Hospital: 1 Inpatier 28a. Date of Injury (Month, Day	/ 2	R/Outpatien 8b. Time of Injury	man .	Bc. Injury Work	OF 4 NL	ırsing Ho	th (Check only on the 5 ☐ Residence 128d. Describe	dence	6	cify)
Division	i ji ji ji	Certification;	3 Suicide 6 Could not be determined		ry - At hom . (Specify)	e, farm, str	eet, factory,	office			28f. Location (City or To	Street an wn, State	d Number or Ri	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funaral Diract completely filled in by	edical		nysician: To the best of miner: On the basis of and manner stat	examinatio							date and	d place, and due	o to the cause(s)
	To t To t Com	M	29b. Signature and title of certified	or wo			29c.		number			4	te signed (Mont	6
	Sm		30. Name and address of person who	349	WW1	coln	Print)	2	Me	otr	ninster	2	MDSI	57
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 0 200	2. Registra	r's Signatu	To doe	Œ)							